Filing at a Glance

Company:	Neighborhood Health Plan of Rhode Island
Product Name:	Neighborhood - Individual Market Product
State:	Rhode Island
TOI:	H16I Individual Health - Major Medical
Sub-TOI:	H16I.005C Individual - Other
Filing Type:	Form/Rate
Date Submitted:	04/15/2013
SERFF Tr Num:	NHRI-128972321
SERFF Status:	Assigned
State Tr Num:	
State Status:	
Co Tr Num:	NHPRI - INDIVIDUAL MARKET - 2
Implementation Date Requested:	On Approval
Author(s):	Arthur Greenwood
Reviewer(s):	Patrick Tigue (primary), Sandra West, Lisa Rallis, Charles DeWeese, Herbert Olson, Bela Gorman, Linda Johnson, Maria Casale
Disposition Date:	
Disposition Status:	
Implementation Date:	

State: Rhode Island **Filing Company:** Neighborhood Health Plan of Rhode Island
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: Neighborhood - Individual Market Product
Project Name/Number: NHPRI Health Exchange 2014 - Individual Market/NHPRI Individual Market 2

General Information

Project Name: NHPRI Health Exchange 2014 - Individual Market
Project Number: NHPRI Individual Market 2
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Arthur Greenwood

Status of Filing in Domicile: Pending

Date Approved in Domicile: 01/01/2014
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Individual
Filing Status Changed: 04/16/2013
State Status Changed:
Created By: Arthur Greenwood
Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null
Exchange Intentions:

These products will only be offered on the Exchange

Filing Description:
April 15 filing of forms and rates for the Individual Market products ON EXCHANGE ONLY

Company and Contact

Filing Contact Information

Art Greenwood,
299 Promenade Street
Providence, RI 02908

agreenwood@nhpri.org
401-459-6685 [Phone]

Filing Company Information

Neighborhood Health Plan of Rhode Island
299 Promenade Street
Providence, RI 02908
(401) 459-6685 ext. [Phone]

CoCode: 95402
Group Code:
Group Name: 0000
FEIN Number: 05-0477052

State of Domicile: Rhode Island
Company Type: Life/Accident/Health
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: $135.00
Retaliatory? No
Fee Explanation: Fee = OHIC Filing Fee $120 (Rate, Form, Supplemental @ $40 each) + SERFF Administrative Fee $15
Per Company: Yes

Company	Amount	Date Processed	Transaction #
Neighborhood Health Plan of Rhode Island	$135.00	04/15/2013	69355677

SERFF Tracking #:	*NHRI-128972321*	***State Tracking #:***		***Company Tracking #:***	*NHPRI - INDIVIDUAL MARKET - 2*

State:	*Rhode Island*	***Filing Company:***	*Neighborhood Health Plan of Rhode Island*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*Neighborhood - Individual Market Product*		
Project Name/Number:	*NHPRI Health Exchange 2014 - Individual Market/NHPRI Individual Market 2*		

Correspondence Summary

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	2013 Rate Review Process OHIC Template - PDF Version	Arthur Greenwood	05/16/2013	05/16/2013
Form	Certificate of Coverages - Individual Market	Arthur Greenwood	05/15/2013	05/15/2013
Form	Benefit Summaries	Arthur Greenwood	05/15/2013	05/15/2013
Supporting Document	PPACA Uniform Compliance Summary	Arthur Greenwood	05/15/2013	05/15/2013
Supporting Document	Regulation 17	Arthur Greenwood	05/15/2013	05/15/2013
Supporting Document	2013 Rate Review Process OHIC Template	Arthur Greenwood	05/15/2013	05/15/2013
Supporting Document	Provider Network Form	Arthur Greenwood	05/15/2013	05/15/2013
Supporting Document	Plans/Benefits Template	Arthur Greenwood	05/15/2013	05/15/2013
Supporting Document	Prescription Drug Template	Arthur Greenwood	05/15/2013	05/15/2013
Supporting Document	Service Area Template	Arthur Greenwood	05/15/2013	05/15/2013

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Individual Market - PPACA Uniform Compliance Summary	Note To Reviewer	Arthur Greenwood	05/08/2013	05/08/2013
Neighborhood Certificate of Coverage and Supporting Documentation	Note To Reviewer	Arthur Greenwood	05/07/2013	05/07/2013

SERFF Tracking #:	*NHRI-128972321*	***State Tracking #:***		***Company Tracking #:***	*NHPRI - INDIVIDUAL MARKET - 2*

State:	*Rhode Island*	***Filing Company:***	*Neighborhood Health Plan of Rhode Island*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*Neighborhood - Individual Market Product*		
Project Name/Number:	*NHPRI Health Exchange 2014 - Individual Market/NHPRI Individual Market 2*		

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Waiver Request from Neighborhood Health Plan of Rhode Island Regarding Financial Capacity Limits	Note To Reviewer	Arthur Greenwood	05/02/2013	05/02/2013
Requested 5-1 Supplemental Rate and Actuarial Memorandum	Note To Reviewer	Arthur Greenwood	05/01/2013	05/01/2013
2013 Form and Rate Review Processes Outstanding Filing Materials Memo- NHPRI	Note To Filer	Patrick Tigue	04/22/2013	04/22/2013
Response to Timeline Request	Note To Reviewer	Arthur Greenwood	04/17/2013	04/17/2013
Timeline Request	Note To Filer	Linda Johnson	04/16/2013	04/16/2013

SERFF Tracking #:	*NHRI-128972321*	***State Tracking #:***		***Company Tracking #:***	*NHPRI - INDIVIDUAL MARKET - 2*

State:	*Rhode Island*	***Filing Company:***	*Neighborhood Health Plan of Rhode Island*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*Neighborhood - Individual Market Product*		
Project Name/Number:	*NHPRI Health Exchange 2014 - Individual Market/NHPRI Individual Market 2*		

Amendment Letter

Submitted Date: 05/16/2013

Comments:

Revised 2013 Rate Review Process - OHIC Template - PDF Version

Changed Items:

No Form Schedule Items Changed.

No Rate Schedule Items Changed.

Supporting Document Schedule Item Changes	
Satisfied - Item:	2013 Rate Review Process OHIC Template - PDF Version
Comments:	2013 Rate Review Process OHIC Template - Individual
Attachment(s):	2013 Rate Review Process OHIC Template - NHPRI - Individual.pdf

SERFF Tracking #:	*NHRI-128972321*	***State Tracking #:***		***Company Tracking #:***	*NHPRI - INDIVIDUAL MARKET - 2*

State:	*Rhode Island*	***Filing Company:***	*Neighborhood Health Plan of Rhode Island*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*Neighborhood - Individual Market Product*		
Project Name/Number:	*NHPRI Health Exchange 2014 - Individual Market/NHPRI Individual Market 2*		

Amendment Letter

Submitted Date: 05/15/2013

Comments:

Attach please find 5-15 updates requested by OHIC staff.

Changed Items:

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Certificate of Coverages - Individual Market	NHPRI Individual - 1	CER	Initial		11.400	05-13 NHPRI CoC Individual (submission copy).pdf	Date Submitted: 05/15/2013 By:
Previous Version								
1	*Certificate of Coverages - Individual Market*	*NHPRI Individual - 1*	*CER*	*Initial*		*12.700*	*Certifcate of Coverage Individual Market - Submission Copy.pdf*	*Date Submitted: 04/15/2013 By: Arthur Greenwood*
2	Benefit Summaries	NHPRI Individual - 2	OTH	Initial		11.400	Benefit Summary - Individual Market - Silver Plan - v2 0.pdf, Benefit Summary - Individual Market - Gold Plan - v2 0.pdf	Date Submitted: 05/15/2013 By:

No Rate Schedule Items Changed.

SERFF Tracking #:	*NHRI-128972321*	***State Tracking #:***		***Company Tracking #:***	*NHPRI - INDIVIDUAL MARKET - 2*

State:	*Rhode Island*	***Filing Company:***	*Neighborhood Health Plan of Rhode Island*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*Neighborhood - Individual Market Product*		
Project Name/Number:	*NHPRI Health Exchange 2014 - Individual Market/NHPRI Individual Market 2*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	PPACA Uniform Compliance Summary
Comments:	
Attachment(s):	PPACA Uniform Compliance Summary-Individual Market - Submission Copy.pdf
Previous Version	
Satisfied - Item:	*PPACA Uniform Compliance Summary*
Comments:	
Attachment(s):	*PPACA Uniform Compliance Summary-Individual Market - Submission Copy.pdf*

Satisfied - Item:	Regulation 17
Comments:	Updated for new CoC submitted on 5-8-13
Attachment(s):	NHPRI Exchange Product - Individual Market - Reg 17 Checklist - (submission copy).pdf
Previous Version	
Satisfied - Item:	*Regulation 17*
Comments:	
Attachment(s):	*NHPRI Exchange Product - Individual Market - Reg 17 Checklist - 4-15 Submission Copy.pdf*

Satisfied - Item:	2013 Rate Review Process OHIC Template
Comments:	
Attachment(s):	2013 Rate Review Process OHIC Template - NHPRI - Individual.xlsx 2013 Rate Review Process OHIC Template - NHPRI - Individual.pdf
Previous Version	
Satisfied - Item:	*2013 Rate Review Process OHIC Template*
Comments:	
Attachment(s):	*2013 Rate Review Process OHIC Template - NHPRI - Individual.xlsx*

Satisfied - Item:	Provider Network Form

SERFF Tracking #:	*NHRI-128972321*	***State Tracking #:***		***Company Tracking #:***	*NHPRI - INDIVIDUAL MARKET - 2*

State:	*Rhode Island*	***Filing Company:***	*Neighborhood Health Plan of Rhode Island*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*Neighborhood - Individual Market Product*		
Project Name/Number:	*NHPRI Health Exchange 2014 - Individual Market/NHPRI Individual Market 2*		

Comments:	Our Network URL has temporarily been pointed to our RiteCare Provider Network. Our Exchange Provider Network is nearly the same and is under construction.
Attachment(s):	Plan_management_data_templates_network.xls

Satisfied - Item:	Plans/Benefits Template
Comments:	Our Benefits URLs have been temporarily pointed to our RiteCare Handbook. Our Exchange Benefits are nearly the same and is under construction.
Attachment(s):	Plan_management_data_templates_plans_benefits - Individual Market.xlsm

Satisfied - Item:	Prescription Drug Template
Comments:	Our Formulary URL has been temporarily pointed to our RiteCare Formulary. Our Exchange Formulary is under construction.
Attachment(s):	Plan_management_data_templates_prescription_drug.xls NHPRI - Formulary - Inadequate Category Justification.pdf

Satisfied - Item:	Service Area Template
Comments:	Attached is our service area template.
Attachment(s):	Plan_management_data_templates_service_area.xls

State: Rhode Island **Filing Company:** Neighborhood Health Plan of Rhode Island
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: Neighborhood - Individual Market Product
Project Name/Number: NHPRI Health Exchange 2014 - Individual Market/NHPRI Individual Market 2

Note To Reviewer

Created By:

Arthur Greenwood on 05/08/2013 12:26 PM

Last Edited By:

Arthur Greenwood

Submitted On:

05/08/2013 12:26 PM

Subject:

Individual Market - PPACA Uniform Compliance Summary

Comments:

Dear Reviewer:

We discovered after filing our CoC yesterday that our PPACA Uniform Compliance Summary did not upload properly. The form is now attached.

Please contact Art Greenwood with any questions or concerns.

Sincerely,
Art Greenwood

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

☑ **INDIVIDUAL HEALTH BENEFIT PLANS** ***(Complete SECTION A only)***

☐ **SMALL / LARGE GROUP HEALTH BENEFIT PLANS** ***(Complete SECTION B only)***

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as "major medical" in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. (*If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.*)

***For all filings, include the Type of Insurance (TOI) in the first column.**

☐ Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
Neighborhood Health Plan of Rhode Island	95402	NHRI-128972321		☑ Yes ☐ No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
H16I	**Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19**	*[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: pp. 86, Ch.6, §1.1; pp. 93, Ch.6, §1.6			
	Eliminate Annual Dollar Limits on Essential Benefits Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Low Vision p. 50, Ch.4, §2.1; Prosthetic Devices p. 60, Ch.4, §2.1; Early Intervention Services p. 41, Ch.4, §2.1			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Infertility p. 42, Ch.4, §2.1; Low Vision p. 50, Ch.4, §2.1			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain
	Explanation:			
	Page Number: pp. 115-116, Ch. 8, §3.5			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: pp viii-xiv - Summary of Benefits; p. 44-46, Ch. 4, §2.1			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: pp. 3-6, Ch. 1, §2.1; p. 8 Ch. 1, §2.3			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: pp. 18 & 20, Ch. 3, §1.3; pp. 98-109, Ch. 7, §§1-6			
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number: pp.26-28 , Ch. 3, §3.1; p. 81, Ch. 5, §1.1			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: pp. 20-22, Ch. 3, §2.1			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: pp. 22-23, Ch. 3, §2.2			

Reset Form

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 of the PHSA/Section 1201 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes**◊ ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

◊ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

State: Rhode Island **Filing Company:** Neighborhood Health Plan of Rhode Island
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: Neighborhood - Individual Market Product
Project Name/Number: NHPRI Health Exchange 2014 - Individual Market/NHPRI Individual Market 2

Note To Reviewer

Created By:

Arthur Greenwood on 05/07/2013 09:08 AM

Last Edited By:

Arthur Greenwood

Submitted On:

05/07/2013 09:09 AM

Subject:

Neighborhood Certificate of Coverage and Supporting Documentation

Comments:

Dear Reviewers:

Attached please find Neighborhood's Individual Market Certificate of Coverage and supporting documentation.

Please contact Art Greenwood with questions regarding this filing.

Sincerely,
Art Greenwood

State: Rhode Island **Filing Company:** Neighborhood Health Plan of Rhode Island
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: Neighborhood - Individual Market Product
Project Name/Number: NHPRI Health Exchange 2014 - Individual Market/NHPRI Individual Market 2

Attachment May 7 Filing - Readability Attestation and Supporting Documentation.zip is not a PDF document and cannot be reproduced here.

Checklist for Individual and Small Group Health Insurance Plans - Policy Form
Inside and Outside the Rhode Island Health Benefit Exchange
Effective for plan years beginning on and after 1-1-2014

Company Name Neighborhood Health Plan of Rhode Island

Product Name: Neighborhood Health Plan Exchange Product 2014 – Individual Market

Plan Name: XXXX

Issuer is:
☐ certified by the Health Benefits Exchange as a QHP issuer
X licensed by OHIC to do health insurance business in RI

SERFF tracking number: NHRI-128972321
TOI Code and Sub Code: H16I – Individual Health – Major Medical
H16G.005C Individual Other

☐60% AV (Bronze)
X 70% AV (Silver)

X 80% (Gold)
☐ 90% (Platinum)
☐ Child-only
☐ Catastrophic Plan - 42 U.S.C. § 18022(e)

Filed for issuance: Inside the Exchange X Outside the Exchange ☐ Inside and Outside the Exchange ☐
Individual Market X Small Group Market☐SHOP ☐ ☐

Instructions for Checklist:

A. The Checklist for Individual and Small Group Health Insurance Plans ("Checklist") must be completed for all major medical health insurance plan policy forms offered by a health insurance issuer (“Issuer”) in the individual market and in the small group market, including individual Qualified Health Plans (“QHP’s”) and SHOP QHP’s offered on the Rhode Island Health Benefit Exchange (“Exchange”).
B. The Checklist does not apply to large group health insurance plans, dental plans, or Medicare Supplemental insurance plans.
C. The terms of applicable laws and regulations shall supersede this Checklist in the case of a conflict. The omission of any requirement of the law or of a regulation from this Checklist in no way limits the authority of the Office of the Health Insurance Commissioner to enforce any other such requirement.
D. A filer shall not change or revise the Checklist.
E. By checking the "Yes" box, the Issuer certifies that the referenced provision of the health insurance plan ("Plan") complies with the associated requirement, and that the referenced provision does not contain any inconsistent, ambiguous, unfair, inequitable, or misleading clauses, or exceptions of conditions that unreasonably affect the risk purported to be assumed.

F. By checking the box "N/A", the Issuer certifies that Plan does not have to comply with the associated requirement. An Explanation must be provided if this box is checked.

G. This Checklist is established by the Commissioner of the Office of the Health Insurance Commissioner ("OHIC") pursuant to OHIC Regulation 17 - "Filing and Review of Health Insurance Plan Forms and Rates." The Checklist is intended to communicate the Commissioner's considered opinion concerning what a Plan form must contain in order to satisfy the statutory and regulatory standards for approval of the form. See R.I. Gen. Laws §§ 27-18-8, 27-19-6, 27-20-6, and 27-41-29.2.

H. The Commissioner may revise the Checklist from time to time. The Checklist, and any revisions to the Checklist, will be posted on SERFF as Filing Instructions for Rhode Island.

I. The filing shall include an actuarial memorandum demonstrating the calculation and analysis used to determine: (a) the Plan's actuarial value rating, and if applicable, (b) the Plan's Catastrophic Plan status, (c) the actuarial equivalence of Essential Health Benefit substitutions, and (d) the conversion of annual or lifetime dollar limits for Essential Health Benefits to a permitted limitation.

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
General Requirements				
1. The filing must contain the entire health insurance plan policy form. • If the filer requests approval of any section, paragraph or other text in the Plan based on prior approval of the text by OHIC, the filer must identify the previously approved filing, and the page, section and paragraph where the text appears in the previously approved filing.	RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2. OHIC Regulation 17		X ☐	☐ X
Explanation: This is Neighborhood's first Certificate of Coverage and has not been previously approved by OHIC .				
2. If changes to a previously approved form are filed, the filing shall include a red-lined version of the previously approved form, and a clean version of the form as proposed to be amended.	RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2. OHIC Regulation 17		☐	X
Explanation: This is Neighborhood's first Certificate of Coverage and has not been previously approved by OHIC				
3. All forms must be filed in a word-searchable format.	RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2 OHIC Regulation 17		X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
Explanation:				
4. Readability. • Forms must comply with the requirements of OHIC Regulation 5, "Standards for the Readability of Health Insurance Forms". • The filing must include a Readability Certification in accordance with OHIC Regulation 5.	45 CFR §156.265(e) RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2 OHIC Regulation 5		X X	☐ ☐
Explanation:				
5. The filing must include the "Compliance Attestation - Forms", attached hereto as Exhibit A.	RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2. OHIC Regulation 17.	Attestation Forms Filed Separately in SERFF On 4/15/2013	X	☐
Explanation:				
Standard Policy Provisions 6. The Plan complies with state laws and regulations relating to: • The Form of the Plan. • Required Provisions • Individual Health Benefit Contracts • Group and Blanket Health Benefit Contracts	 R.I. Gen. Laws § 27-18-2 R.I. Gen. Laws § 27-18-3 OHIC/DBR Regulation 23, Part VII OHIC/DBR Regulation 23, Part VIII	 p. 6-8, Ch. 1, §2.2 pp. 112-116, Ch. 8, §§1-3 pp. 36-38, Ch. 4, §2.1 p. 143, Ch. 10 p. 112, Ch. 8, §1 p. 36, Ch. 4, §2.1	 X X X X	 ☐ ☐ ☐ ☐
Explanation:				

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
Form Content Requirements X				
7. Essential Health Benefits ("EHB") a) The Plan must cover each of the 10 categories of Essential Health Benefits: o Ambulatory patient services o Emergency services o Hospitalization o Maternity and newborn care o Mental health and substance use disorder services, including behavioral health treatment o Prescription drugs o Rehabilitative and habilitative services and devices o Laboratory services o Preventive and wellness services and chronic disease o Pediatric services, including oral and vision care	42 U.S.C. § 18022 45 C.F.R. § 156.100 et seq.	pp viii-xiv - Summary of Benefits pp. 36-65, Ch. 4, §§ 2 & 3	X	☐
b) The provisions of this Section 7 apply to benefits and services covered under the Plan. The provisions of this Section 7 do not apply to cost sharing, and do not apply to utilization review standards and procedures.				
c) The Plan must cover each and every service covered in the EHB-Benchmark Plan. The components of the EHB-Benchmark Plan are: (1) the Blue Cross Vantage Blue Small Group plan ("the Base-Benchmark Plan"), including the prescription drug benefits covered by the Base-Benchmark Plan; (2) the pediatric dental benefits covered under the MetLife Federal Dental plan; (3) the pediatric vision benefits covered under the FEP Blue Vision plan; and (4) habilitative services as determined and required by subsection (h), below. Note: OHIC considers each of the benefits and services covered in the Base-Benchmark Plan to be included within one of the 10 Essential Health Benefits listed in subsection		pp viii-xiv - Summary of Benefits pp. 36-65, Ch. 4, §§ 2 & 3	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
(a), above. If the filer proposes to exclude a benefit or service covered in the R.I. Benchmark Selections, because the filer considers the benefit or service to be not included within one of the 10 Essential Health Benefits listed in subsection (a), above, the filer must identify such benefit or services, and provide a written explanation for the exclusion. The components of the EHB-Benchmark Plan (other than habilitation services required by subsection (h), below, can be found at the following address on the OHIC website: http://www.ohic.ri.gov/2010%20Health_Reform.php				
d) The Plan must cover the services covered in the EHB-Benchmark Plan, including but not limited to each and every state benefit mandate covered in the Base-Benchmark Plan.		pp viii-xiv - Summary of Benefits pp. 36-65, Ch. 4, §§ 2 & 3	X	☐
e) Prescription drugs. ○ The filer must include the Plan's prescription drug formulary with the filing. ○ The Plan must cover the greater of: (i) one drug in each United States Pharmacopeia ("USP") category or class, or (ii) the same number of prescription drugs covered in the Base-Benchmark Plan. ○ The Plan may substitute a prescription drug covered under the Base-Benchmark Plan, provided that the substituted drug covered under the Plan is in the same USP category or class as the drug covered under the Base-Benchmark Plan. The Issuer shall identify any drug substitutions, and shall verify that the therapeutic category or class of the substituted drug covered under the Plan is the same as the therapeutic category or class of the drug covered under the Base-Benchmark Plan. In the case of formulary substitutions during the Plan year, the Issuer shall file on SERFF a notification (not subject to prior approval) identifying the substitution that has		pp. 61-65, Ch. 4, §3	X X X	☐ ☐ ☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
been made, and verifying that the USB category or class of the substituted drug covered under the Plan is the same as the USP category or class of the drug covered under the Base-Benchmark Plan. ○ The Plan shall describe the process for an enrollee to request and receive coverage of clinically appropriate drugs not on the Plan's formulary.		p. 64, Ch. 4, §3.2	X	☐
f) A Plan that is offered outside the Exchange must cover the pediatric dental services covered by the EHB-Benchmark Plan (the MetLife Federal Dental plan for federal employees), for enrollees 18 years of age or younger; except that a Plan that is offered outside the Exchange is not required to cover the pediatric dental services covered by the EHB-Benchmark Plan if the Issuer determines, after reasonable inquiry, that the individual or small group policyholder is covered under a dental insurance plan that covers the pediatric dental services covered by the EHB-Benchmark Plan. If the individual or small group policyholder is already covered under a dental insurance plan that covers the pediatric dental services covered by the EHB-Benchmark Plan, the Issuer shall not offer the Plan with pediatric dental services; instead, the Issuer must offer a Plan that excludes pediatric dental coverage, with a premium discount equivalent to the per member per month cost of pediatric dental coverage. The Issuer's rate filing for the Plan shall include the proposed premium for the Plan with and without pediatric dental services.		Plan will not be offered outside the Exchange; therefore no Pediatric Dental is required.	☐ X	X ☐
g) The Plan must cover the pediatric vision services covered under EHB-Benchmark Plan (the FEP Blue Vision plan for federal employees) for enrollees 18 years of age or younger.		pp 47-50, Ch. 4, §2.1	X	☐
h) The Plan must cover habilitative services as approved by the Commissioner, in accordance with the following: Habilitative services covered under the Plan must be defined by scope, and		p. 46, Ch. 4, §2.1 p. 133, Ch. 10	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
must be at least as comprehensive (measured by per member per month cost) as the per member per month cost of rehabilitation services covered under the plan. Service visit limitations or other durational or quantitative limitations will be approved by the Commissioner only if the filer can demonstrate that no other qualitative, evidenced-based limitations less burdensome to the consumer (e.g. a process for developing limitations based on individual assessments of need) are feasible and appropriate. The filer must attach in the filing an Exhibit that (1) identifies the habilitative services covered by the plan, (2) includes an actuarial memorandum estimating the per member per month cost of the habilitative and rehabilitative services covered, and (3) includes in the actuarial memorandum the calculation and analysis used to develop the identified cost. No later than 90 days after the end of each calendar year, the Issuer must file with OHIC an actuarial memorandum, using the best available claims data, describing the Plan's claims and expense experience for habilitative and rehabilitative services during the preceding Plan year, and comparing such claims and expense experience with the approved rate factor.		Neighborhood is not placing a limit on Habilitative Services	X	☐
			X	☐
i) Substitutions. o A Plan may substitute a benefit or service for a benefit or service covered under the EHB-Benchmark Plan only if: (1) the Plan's substitute benefit or service is included within the same Essential Health Benefit category (see subsection (a), above) as the benefit or service covered under the EHB-Benchmark Plan; (2) the substitute benefit or service and the substituted benefit or service are actuarially equivalent; and (3) the substitution is approved by the Commissioner. o The filer must identify the substitution, and must file an actuarial memorandum demonstrating that the substitution is actuarially equivalent.		No substitution proposed	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
j) A Plan may include a material deviation from a benefit or service for a benefit or service covered under the EHB-Benchmark Plan only if (1) the deviation is identified; (2) the Issuer files a memorandum demonstrating that the deviation is substantially equivalent to the EHB-Benchmark Plan; and (3) the deviation is approved by the Commissioner.		No material deviations proposed	X	☐
Explanation:				
8. Cost-sharing. • Out of pocket limits. The Issuer must demonstrate in an Exhibit filed with the Plan that annual out of pocket cost sharing under the Plan does not exceed the limits established by federal and state laws and regulations, including any revisions to this Checklist. • Deductible limits. For small group Plans, the Issuer must demonstrate in an Exhibit filed with the Plan that annual deductibles under the Plan do not exceed the limits established by federal and state laws and regulations, including any revisions to this Checklist.	42 U.S.C. § 18022(c) 45 C.F.R. § 156.130(a)	pp viii-xiv - Summary of Benefits pp. 34-35, Ch. 4, § 1.3	X X	☐ ☐
Explanation:				
9. The Plan must contain no preexisting condition exclusions.	42 U.S.C. § 300gg-3 RI Gen Law §§ 27-18-71, 27-18.5-10, 27-19-68, 27-20-57, 27-41-81	pp. 86, Ch.6, §1.1 pp. 93, Ch.6, §1.6	X	☐
Explanation:				

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
10. Lifetime dollar limits. • The Plan must contain no lifetime limits on the dollar value of any Essential Health Benefits, including the specific benefits and services covered under the EHB-Benchmark Plan. See Para. 7, above. • If the specific benefits and services covered under the Base-Benchmark Plan (See Para. 7, above) include dollar limits on the coverage of any such benefit or service, the Plan may propose an actuarially equivalent conversion of the dollar limit to a utilization limit, or some other quantitative or qualitative limit, subject to the Commissioner's approval. • If the Plan proposes a conversion the Issuer must file with the Plan an actuarial memorandum supporting the actuarially equivalent conversion.	PHSA §2711 45 CFR §147.126 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2	Infertility p. 42, Ch.4, §2.1 Low Vision p. 50, Ch.4, §2.1	X ☐	☐ X X
Explanation: **Plan does not include any lifetime dollar or utilization limits for EHB**.				
11. Annual dollar limits. a) The Plan must contain no lifetime limits on the dollar value of any Essential Health Benefits, including the specific benefits and services covered under the EHB-Benchmark Plan. See Para. 7, above. b) If the specific benefits and services covered under the Base-Benchmark Plan (See Para. 7, above) include dollar limits on the coverage of any such benefit or service, the Plan may propose an actuarially equivalent conversion of the dollar limit to a utilization limit, or some other quantitative or qualitative limit, subject to the Commissioner's approval. c) If the Plan proposes a conversion the Issuer must file with the Plan an actuarial memorandum supporting the actuarially equivalent conversion.	42 U.S.C. § 300gg-11 45 CFR §147.126 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2	Low Vision p. 50, Ch.4, §2.1 Prosthetic Devices p. 60, Ch.4, §2.1 Early Intervention Services p. 41, Ch.4, §2.1	X X ☐	☐ ☐ X
Explanation: **Plan does not include any annual dollar or utilization limits for EHB**				

Requirement	Federal & State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
12. The Plan must state that the Issuer may not rescind the Plan except in cases of fraud or intentional misrepresentation of material fact. The Plan must also state that coverage may not be contested 2 years after issuance of the Plan for any reason. • Rescission is a cancellation of coverage that has retroactive effect. It includes a cancellation that voids benefits paid. • Coverage may not be rescinded except with 30 days prior notice to each enrolled person who would be affected.	42 U.S.C. § 300gg-12 45 CFR §147.128 RI Gen Law §§ 27-18-8, 27-18-72, 27-19-6, 27-19-62, 27-20-6, 27-20-58, 27-41-29.2 OHIC/DBR Reg. 23 Part VIII, Section 1(2)	pp. 115-116, Ch. 8, §3.5	X	☐
Explanation:				
13. The Plan must cover preventive services without cost sharing requirements including deductibles, co-payments, and co-insurance. • Covered preventive services include: o Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the USPSTF; o Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (CDC); o Evidence-informed preventive care and screenings provided for in HRSA guidelines for infants, children, adolescents, and women; and o Current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention.	PHSA §2713 45 CFR §147.130 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2	pp viii-xiv - Summary of Benefits p. 44-46, Ch. 4, §2.1	X	☐
Explanation:				
14. The Plan must provide coverage for dependents up to age 26 if the Plan offers dependent coverage. • Eligible children are defined based on their relationship with the participant.	42 U.S.A. § 300gg-14 45 CFR §147.120	pp. 3-6, Ch. 1, §2.1 p. 8 Ch. 1, §2.3	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
• Limiting eligibility is prohibited based on: o financial dependency on primary subscriber, o residency, o student status, o employment, o eligibility for other coverage, o marital status. • Terms of the policy for dependent coverage cannot vary based on the age of a child.	RI Gen Law §§ 27-18-59, 27-19-50, 27-20-45, 27-41-61			
Explanation:				
15. The Plan must cover emergency services in accordance with the following: • No prior authorization. • No limitation to only services and care at participating providers. • Must cover at in-network cost-sharing level (patient is not penalized for emergency care at out-of-network provider). • Must pay for out-of-network emergency services the greatest of: (1) The median in-network rate; (2) the usual customary and reasonable rate (or similar rate determined using the plans or issuer's general formula for determining payments for out-of-network services); or (3) the Medicare rate.	42 U.S.C. § 300gg-19a(b) 45 CFR §147.138 RI Gen Law §§ 27-18-76, 27-19-66, 27-20-62, 27-41-79 SSA §1395dd	pp.26-28 , Ch. 3, §3.1 p. 81, Ch. 5, §1.1	X	☐
Explanation:				
16. For network plans requiring a primary care provider to be designated and requiring referrals: • The Plan must allow each enrollee to designate any participating primary care provider who is available to accept such individual. • The Plan must permit a physician specializing in pediatrics to	42 U.S.C. § 300gg-19a(a), (c), and (d) 45 CFR §147.138	pp. 20-22, Ch. 3, §2.1	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
• be designated as primary care provider. • The Plan must not require a referral for services to be provided by in-network OB/GYNs. The Plan must treat the ordering of OB/GYN items or services by an OB/GYN as it had been ordered or authorized by the primary care provider.	RI Gen Law §§ 27-18-44	pp. 22-23, Ch. 3, §2.2	X X X	☐ ☐ ☐
Explanation:				
17. In connection with maternity coverage, the Plan must provide coverage as follows: • Benefits may not be restricted to less than 48 hours following a vaginal delivery, and 96 hours following a cesarean section. This requirement does not apply if the provider, in consultation with the mother, decides to discharge the mother or the newborn prior to the minimum length of stay. • No prior authorization required for the minimum hospital stay. • For purposes of maternity coverage requirements, hospital length of stay begins at the time of delivery if delivery occurs in a hospital and at time of admission in connection with childbirth if delivery occurs outside the hospital. • No denial of mother/newborn eligibility, continued eligibility, to enroll or to renew coverage to avoid these requirements. • No monetary payments or rebates to encourage mothers to accept less than the minimum stay requirements. • No penalty for an attending provider who provides services in accordance with these requirements. • No incentives to an attending provider to induce the provider to provide care inconsistent with these requirements. • No restriction of benefits for any portion of a period within the minimum stay periods in a manner less favorable than the benefits provided for any preceding portion of such stay. • No requirement that the mother give birth in a hospital.	42 U.S.C. § 300gg-25 45 CFR §148.170 RI Gen Law §§ 27-18-33.1, 27-19-23.1, 27-20-17.1, 27-41-33.1, 27-41-43 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2	pp. 52-53, Ch. 4, §2.1	X X X	☐ ☐ ☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
No requirement that the mother to stay in the hospital for a fixed period of time following the birth of her child.				
Explanation:				
18. The Plan must state that it provides, and must provide coverage for parity in mental health and substance use disorder benefits ("Parity"), in accordance with the following: • Coverage for the medical treatment of mental illness and substance abuse must be provided under the same terms and conditions as that coverage is provided for other illnesses and diseases. • The Plan must describe, through illustrations, FAQ's, or other consumer explanation how the Plan provides for Parity in connection with financial requirements, quantitative treatment limitations, prescription drug benefits, and non-quantitative treatment limitations.	42 U.S.C. § 300gg-26 45 CFR §146.136 RI Gen Law § 27-38.2-1	pp. 53 + 55, Ch. 4, §2.1	X	☐
Explanation:				
19. The Plan must provide coverage for reconstructive surgery after mastectomy (Women's Health and Cancer Rights Act). The Plan must describe, through illustrations, FAQ's, or other consumer explanation how the Plan covers reconstructive surgery after mastectomy, including the scope of coverage, and cost-sharing consistent with other medical/surgical benefits.	PHSA §2727 RI Gen Law §§27-8-39, , 27-20-29, 27-41-43 OHIC Reg. 17	pp. 50-51, Ch. 4, §2.1	X	☐
Explanation:				
20. The Plan must state that coverage is guaranteed renewable, and that the Issuer may non-renew or cancel coverage under the Plan only for nonpayment of premiums, fraud, market exit, movement outside of service area, or cessation of bona-fide association membership.		p. 116, Ch. 8, §5.1	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
	RI Gen Law § 27-18.5-4			
Explanation:				
21. The Plan must state that it does not limit coverage based on genetic information. 22. The Plan must state that the Issuer will not: (i) adjust premiums based on genetic information; (ii) request /require genetic testing; (iii) or collect genetic information from an individual prior to, or in connection with enrollment in a plan, or at any time for underwriting purposes.	PHSA §2753 45 CFR §148.180 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2	p. 122, Ch. 9, §1.3	X X	☐ ☐
Explanation:				
23. The Plan must provide coverage for individuals participating in approved clinical trials. The Plan must describe, through illustrations, FAQ's, or other consumer explanation how the Plan provides such coverage, including the scope of coverage, individuals qualified, clinical trials that will be approved, and network provider limitations.	42 U.S.C. § 300gg-8 RI Gen Law §§ 27-18-74, 27-19-64, 27-20-60, 27-41-77	pp. 56-57, Ch. 4, §2.1	X	☐
Explanation:				
24. The Plan must state that the enrollee may terminate coverage upon no greater than 14 days notice to the Issuer or the Exchange. 25. For QHPs only, the Plan must state that the Issuer is permitted to terminate coverage if: • The enrollee is no longer eligible for coverage through the Exchange. • Payment of premiums cease (after appropriate grace periods	45 CFR § 155.430 45 CFR § 156.270(d) - (g) RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2 RI Gen Law § 27-18-3(a)(3);	p. 112, Ch. 8, §2.1 pp. 112-114, Ch. 8, §2.1	X X	☐ ☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
applied as described below); • The enrollee's coverage is rescinded for a non-prohibited reason. • The Qualified Health Plan is terminated or decertified. • The enrollee changes from one plan to another through during an open or special enrollment period.				
26. The Plan must state that if coverage is terminated, 30 days prior notice is required, and the notice must include the reason for termination.		p. 113, Ch. 8, §2.1	X	☐
27. The Plan must state that a 3 month grace period is provided for enrollees in a Qualified Health Plan who are recipients of advance payments of premium tax credit. The Issuer must provide the enrollee with notice of payment delinquency, unless the Exchange has accepted the obligation to do so on behalf of the Issuer.		p. 113, Ch. 8, §2.1	X	☐
28. For all other enrollees, the Plan must state that a 30 day grace period is provided.		p. 113, Ch. 8, §2.1	X	☐
Explanation:				
Claims, Internal Appeals, and External Appeals 29. The Plan must include a description of its claims procedures, procedures for obtaining prior approval, preauthorization procedures, utilization review procedures, adverse benefit determination procedures, internal appeals, external appeals, and the applicable time frames for these policies and procedures. Such policies and procedures must be in accordance with federal laws and regulations, in accordance with state laws and regulations that are not in conflict with such federal laws and regulations, and in accordance with the requirements of this checklist.	42 U.S.C. § 300gg-19 45 CFR § 147.136 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2 RI Gen Law §§ 23-17.12-1 et seq., 23-17-13-1 et seq. (where not in conflict with federal laws and regulations).	pp. 18 & 20, Ch. 3, §1.3 pp. 98-109, Ch. 7, §§1-6	X	☐
30. The Plan must include the standards, including the Plan's medical		pp.17 + 18, Ch. 3, §1.2 p. 133, Ch. 10	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
necessity standard, applicable to prior approval, preauthorization, and utilization review procedures. The Plan's definition of "medical necessity" must: • Require coverage of health care services that are appropriate, in terms of type, amount, frequency, level, setting, and duration to the member's diagnosis or condition. • Must be informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters.	DOH Regulations 23-17-12-UR and 23-17.13-CHP (where not in conflict with federal laws and regulations).			
31. The Plan must explain to the enrollee how to obtain the clinical review criteria used to determine medical necessity in a particular situation.		p. 108, Ch. 7, §5.2	X	☐
32. The Plan's definition of adverse benefit determination must be the definition used in 29 C.F.R. § 2560.530-1. The term also includes a rescission of coverage.		p. 103, Ch. 7, §4.1	X	☐
33. In connection with external appeals, the Plan must provide that: • The cost of an external appeal must be borne by the issuer. • The claimant must not be charged a filing fee greater than $25. • Restrictions on the minimum dollar amount of a claim are not allowed. • The decision of the Independent Review Organization is binding on the issuer.		pp. 107-109, Ch. 7, §5	X	☐
Explanation:				

Certificate of Coverage

Neighborhood Health Plan of Rhode Island

INDIV (05-13)

WELCOME

Welcome to Neighborhood Health Plan of Rhode Island (Neighborhood). Below are a legal notice, some helpful tips, and phone numbers about your plan.

NOTICE

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

Words in *italics* (like *member* and *covered services*) have specific meanings in this Booklet. You can find these meanings listed in Chapter 10 at the end of this Booklet.This contract is solely between you and Neighborhood Health Plan of Rhode Island. Neighborhood Health Plan of Rhode Island is a Rhode Island non-profit, tax-exempt corporation formed by, and continues to be controlled by, Rhode Island's community health centers.

James A. Hooley,

Chief Executive Officer

PLEASE READ AND SAVE THIS DOCUMENT

This book is your *certificate of coverage* with Neighborhood Health Plan of Rhode Island (Neighborhood) and explains the benefits specific to your plan.

This booklet gives you the details about your health care *coverage* from January 1 – December 31, 2014. It explains how to get coverage for the health care services you need.

This is an important legal document. Please keep it in a safe place.

HELPFUL HINTS

- Read all information provided, Become familiar with services excluded from *coverage* (See Chapter 4, Section 4 – Benefits not *covered* by the plan.)

- In Chapter 10 – Glossary, there is a list of definitions of words used throughout this agreement. It is very helpful to become familiar with these words and their definitions. Words that are in *italics* have definitions in Chapter 10 at the end of this agreement.

- Member identification cards (Member ID) are provided to all Members. The Member ID card must be shown when obtaining health care services. Your Member ID card should be kept in a safe location, just like money, credit cards or other important documents. Neighborhood should be notified immediately if your Member ID card is lost or stolen.

- Our list of *network provider*s changes from time to time. You may want to call our *Member Services* Department in advance to make sure that a *provider* is a *network provider*.

- You are encouraged to become involved in your health care treatment by asking *provider*s about all treatment plans available and their costs. You also are encouraged to take advantage of the preventive health services offered under this agreement to help you stay healthy and find problems before they become serious.

IMPORTANT TELEPHONE NUMBERS, ADDRESSES, AND WEBSITES

Emergency care

For routine care, always call your *Primary Care Provider* (*PCP*). Do this before seeking care anywhere else. If you have an urgent medical need and cannot reach your *PCP* or your *PCP*'s covering *provider*, seek care at the nearest emergency room.

Important Note: If needed, call 911 for emergency medical assistance. If 911 services are not available in your area, call the local number for *emergency* medical services.

***Member Services* department**

Hours of Operation: Monday through Friday 8:30 a.m. – 5:00 p.m.

Call our Member Services Department at **855-321-XCHG (855-321-9244)** for general questions, assistance in selecting a Primary Care Physician (*PCP*), benefit questions, and information regarding eligibility for enrollment and billing.

Services for hearing impaired Members

Telecommunications Device for the Deaf – (Voice TDD) **401-459-6690**.

Mental health services

You may need information regarding mental health professionals in your area. If so, please call the Mental Health Department at 1-800-215-0058.

Our Website – provides additional information about Neighborhood Health Plan of Rhode Island as well as resources specific to your plan, such as formulary, *provider* directory and benefit plan descriptions. Please see Neighborhood Health Plan of Rhode Island's web site at **www.nhpri.org**

Grievance and Appeals unit

If you need to call us about a concern or *appeal*, please call *Member Services* at **855-321-XCHG (855-321-9244)** or, to submit an *appeal* or *complaint* in writing, please send your letter to:

Neighborhood Health Plan of Rhode Island
Attn: Grievance and Appeals Unit
299 Promenade Street
Providence, RI 02908

Translator Services

Our plan has people and free language interpreter services available to answer questions from non-English speaking Members. For information, please call our *Member Services* Department.

Preauthorization

Neighborhood only covers a service listed in this *certificate of coverage* if we or our designee determine that the care is *medically necessary*. *Preauthorization* is required for certain *covered services*. Services for which *preauthorization* is required are marked with an asterisk (*) in the Summary of Medical Benefits.

- **Medical/Surgical -** call our *Member Services* Department 855-321-XCHG (855-321-9244.
- **Mental Health and Chemical Dependency -** call 1-800-215-0058 before having care. Lines are open 24 hours a day, 7 days per week.

Your *network provider* is responsible for obtaining *preauthorization* for in-network *covered services*. If you would like to use a non-*network* provider for non-*emergency* services, and have us *cover* those services, you must request and obtain *preauthorization* from us first. Please call *Member Services* at 1-800-459-6019. Neighborhood's Medical Management Department will review your request for services.

2014 Certificate of Coverage

Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. You will find a detailed list of topics at the beginning of each chapter.

Benefit Overview

This table provides basic information about your benefits under this plan. See *Benefit Limits(defined in Chapter 10)* and Chapter 4 for detailed explanations of *Covered Services*. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

MEDICAL DEDUCTIBLE

The *Deductible* is the amount you and the enrolled *Members* of your family (if applicable) must pay each year for certain *Covered Services* before payments are made under this certificate of coverage.
Individual Medical *Deductible*..... $250-$3,000 per *Contract Year*
Family Medical *Deductible* ..... $500-$6,000 per *Contract Year*

This Family Medical *Deductible* applies for all enrolled *Members* of a family. All amounts any enrolled *Members* in a family pay toward their Individual *Deductibles* are applied toward the Family *Deductible*. The Family Medical *Deductible* is satisfied in a *Contract Year* when:

•one enrolled *Member* in family meets his or her $250-$3,000 Individual *Deductible*; **and**
•one or more additional enrolled *Members* in that family have paid toward their Individual Medical *Deductibles* a collective amount equal to the remaining balance of the family deductible in any combination. Once the Family Medical *Deductible* has been met during a *Contract Year*, all enrolled *Members* in a family will thereafter have satisfied their Individual *Deductibles* for the remainder of that *Contract Year.*

• The following are not subject to the Medical *Deductible*:
•*Emergency* care;
• Office visits for preventive care; office visits* for family planning; office visits to diagnose and treat illness or injury; mental health and substance abuse services; routine ob/gyn exam; routine eye exam; other vision care from an optometrist; *Outpatient* maternity care (pre-natal and post-partum)**; pediatric dental care; spinal manipulation; chiropractic medicine; nutritional counseling; and health education.
*including diagnostic tests associated with preventive health care, as described in Chapter 4.
**This does not include diagnostic tests such as ultrasounds.
•routine cytological exams (Pap Smears);
•early intervention services for a *Dependent Child;*
•preventive immunizations;
•routine mammograms;
•prostate and colorectal exams;
Any amounts you pay for prescription drugs. A separate *Deductible* applies to your prescription drug coverage. For more information, see "Prescription Drug Benefit" in Chapter 4.
•Any amount you pay for services, supplies, or medications that are not *Covered Services*.
• Once you meet your *Deductible* in a *Contract Year* for *Covered Services*, you pay only the following:
•Office visit *Copayment* for *Covered Services* not subject to the *Deductible*.
•Copayments for Emergency room; Inpatient Services*;* Day Surgery*;*
- ConinsuranceCopayments for Emergency room; Inpatient Services*;* Day Surgery*;*

Benefit Overview (continued)

PHARMACY *DEDUCTIBLE*

The Pharmacy *Deductible* is the amount you and the enrolled *Members* of your family (if applicable) must pay each year for certain *Covered Pharmacy Services* before payments are made under this certificate of c*overage*.

Individual Pharmacy *Deductible*..... $10-$250 per *Contract Year*
Family Pharmacy *Deductible* .....$20-$500 per *Contract Year*

This Family Pharmacy *Deductible* applies for all enrolled *Members* of a family. All amounts any enrolled *Members* in a family pay toward their Individual *Deductibles* are applied toward the Family Pharmacy *Deductible*. The Family *Deductible* is satisfied in a *Contract Year* when:

•one enrolled *Member* in family meets his or her $10-$250 Individual *Deductible*; **and**
•one or more additional enrolled *Members* in that family have paid toward their Individual *Deductibles* a collective amount equal to the remaining balance of the family deductible in any combination.

Once the Family *Deductible* has been met during a *Contract Year*, all enrolled *Members* in a family will thereafter have satisfied their Individual *Deductibles* for the remainder of that *Contract Year*.

Benefit Overview

COINSURANCE

Except as described in the "Benefit Overview" table below, the *Member* pays [0-30%] after the deductible is satisfied of the *Reasonable Charge* for certain *Covered Services*. The *Member* is also responsible for any charges in excess of the *Reasonable Charge*.

COPAYMENTS

• ***Emergency* Care:**
• Emergency room.....$25 - $200 *Copayment* per visit
• In *Provider's* office .....$5 - $50 *Copayment* per visit for care received from a Neighborhood provider.

Notes:

• An Emergency Room *Copayment* may apply if you register in an Emergency room but leave that facility without receiving care.
• A *Day Surgery Copayment* may apply if *Day Surgery* services are received.
• Urgent Care .. $5-$50 *Copayment* varies depending on type of *Provider* (*PCP* or Specialist) and location in which service is rendered (for example, *Emergency Room,* urgent care center, or physician's office).per visit

•Other *Covered Services*:

• Office Visit.....$5 -$50 - *Copayment* per visit for office visits.

Note: This *Copayment* applies to covered *Outpatient* care provided by your *PCP*, amental health/substance abuse *Provider*, or an obstetrician/ gynecologist ("Ob/Gyn"),as well as for *Outpatient* - physical, occupational, or speech therapy services, spinal manipulation, chiropractic medicine; acupuncture; early intervention services for a *dependent child*, cardiac rehabilitation services, and routine eye care.

Note: Certain *Outpatient* services may be listed as "covered in full" in the table below. If so, you may be charged the *Deductible* (if applicable) and an Office Visit *Copayment* when these services are provided

Benefit Overview (continued)

along with an office visit. In addition, please note that in accordance with the Patient Protection and Affordable Care Act (PPACA), certain services are not subject to a *Cost Sharing Amount* . Please see the following Benefit Overview chart for more information.

Benefit Overview, continued

MEDICAL OUT-OF-POCKET MAXIMUM

The Medical *Out-of-Pocket Maximum* is limited to the maximum dollar amount as defined each year by the Internal Revenue Service. For more information*,* see the definition of "*Out-of-Pocket Maximum"* in Appendix A.

The amount of the Medical *Out-of-Pocket Maximum* for you and the enrolled members of your family (if applicable) each c*ontract year* is:

Family Size Medical*Out-of-Pocket Maximum Amount*

- One Member..... $750- $5,000 per person.
- Two Members or more.....$1,500- $10,000 per family.

***Medical Out-of-Pocket Maximum* (Individual)**

This certificate of coverage has an individual Medical *Out-of-Pocket Maximum* of $750-$5,000 per *Member* per *Contract Year* for all *Covered Services.* Only *Copayments* , Deductibles and *Coinsurance* counts toward the Medical *Out-of-Pocket Maximum.* For more information , see the definition of *"Out-of-Pocket Maximum*" in Appendix A.

Medical *Out-of-Pocket Maximum* - (Family*)*

The Family Medical *Out-of-Pocket Maximum* is satisfied in *Contract Year* when enrolled *Members* in a family each meet their $750-$5,000 Individual Medical *Out-of-Pocket Maximum*. The Family Medical *Out-of-Pocket Maximum* is satisfied in a *Contract Year* when:

- one enrolled *Member* in family meets his or her $750-$5,000 Individual *Out-of-Pocket Maximum*; **and**
- one or more additional enrolled *Members* in that family have paid toward their Individual Medical *Out-of-Pocket Maximum* a collective amount equal to the remaining balance of the Family Medical *Out-of-Pocket Maximum.*

All amounts any enrolled *Members* in a family pay toward their Individual *Out-of-Pocket Maximums* are applied toward the $1,500-$10,000 Family Medical *Out-of-Pocket Maximum*. Once the Family *Out-of-Pocket Maximum* has been met during a *Contract Year*, all enrolled *Members* in a family will thereafter have satisfied their Individual Medical *Out-of-Pocket Maximums* for the remainder of that *Contract Year.*

Pharmacy *OUT-OF-POCKET MAXIMUM*

This certificate of coverage has an individual Pharmacy *Out-of-Pocket Maximum* of $100-$1,000 per *Member* per *Contract Year* for all *Covered Services.* Only *Copayments* , Deductibles and *Coinsurance* counts toward the Pharmacy *Out-of-Pocket Maximum.* For more information , see the definition of *"Out-of-Pocket Maximum*" in Appendix A.

The amount of the Pharmacy *Out-of-Pocket Maximum* for you and the enrolled members of your family (if applicable) each contract year is:

Benefit Overview (continued)

Family Size Pharmacy*Out-of-Pocket Maximum Amount*

• One Member..... $100- $1,000 per person.
• Two Members or more.....$200- $2,000 per family.

Pharmacy Out-of-Pocket Maximum **(Individual)**
The amount of the Pharmacy *Out-of-Pocket Maximum* for you and the enrolled members of your family (if applicable) each c*ontract year* is:
Family Size Pharmacy*Out-of-Pocket Maximum Amount*
• One Member..... $100- $1,000 per person.
• Two Members or more.....$200- $2,000 per family.

Pharmacy *Out-of-Pocket Maximum* - (Family*)*

The Family Pharmacy *Out-of-Pocket Maximum* is satisfied in *Contract Year* when enrolled *Members* in a family each meet their $100-$1,000 Individual Pharmacy *Out-of-Pocket Maximum*. The Family Pharmacy *Out-of-Pocket Maximum* is satisfied in a *Contract Year* when:
• one enrolled *Member* in family meets his or her $200-$2,000 Individual *Out-of-Pocket Maximum*; **and**
• one or more additional enrolled *Members* in that family have paid toward their Individual Pharmacy *Out-of-Pocket Maximum* a collective amount equal to the remaining balance of the Family Pharmacy *Out-of-Pocket Maximum.*

All amounts any enrolled *Members* in a family pay toward their Individual *Out-of-Pocket Maximums* are applied toward the $200-$2,000 Family Pharmacy *Out-of-Pocket Maximum*. Once the Family *Out-of-Pocket Maximum* has been met during a *Contract Year*, all enrolled *Members* in a family will thereafter have satisfied their Individual Pharmacy *Out-of-Pocket Maximums* for the remainder of that *Contract Year.*

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	Your Cost	Page
Emergency Care		
Treatment in an Emergency Room	*Copayment* per visit applies. (Waived if admitted as an *Inpatient* or for *Day Surgery*) **Note:** *Observation* services will not take an *Emergency* room *Copayment*.]	38
Treatment in a *Provider's* office	Care from a Neighborhood provider *Copayment* per visit applies	38
A *Member* should call *Neighborhood Health Plan* within 48 hours after *Emergency* Care is received. If you are admitted as an *Inpatient*, we recommend that you or someone acting for you call your *PCP* or *Neighborhood Health Plan* within 48 hours. A *Day Surgery Copayment* may apply if *Day Surgery* services are received.		
***Outpatient* Care**		
Allergy Testing **(PA)**	Deductible and coinsurance apply; no copayments apply .	38
Cardiac rehabilitation **(PA) (BL)**	Deductible and coinsurance apply; no copayments apply .	38
Chemotherapy	*Deductible* and c*oinsurance apply*.	38
Chiropractic **(BL), (PA)**	*Deductible* and c*oinsurance apply*.	38
Contraceptive Services	*Deductible* and c*oinsurance apply*.	39
Diabetes Services and Supplies **(PA)**	Diabetic test strips: *Deductible* and c*oinsurance apply*. Diabetes self-management education: *Deductible* and c*oinsurance apply*. Diabetes supplies covered as *Durable Pharmacy Equipment*: *Deductible* applies Diabetes supplies covered as pharmacy supplies: *Deductible* applies For information about your cost for diabetes supplies covered as prescription medication, see "Prescription Drug Benefit" in Chapter 4.	39

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Benefit Overview, continued
Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	**Your Cost**	**Page**
***Outpatient* Care, continued**		
Diagnostic Imaging **(PA)**	**Office Visit**: *Deductible* and c*oinsurance apply*.. ***Day Surgery**; Deductible* and c*oinsurance apply*. *Surgery* admission to a *Hospital* *This *Copayment* also applies for *Covered Day Surgery* services at a free- standing surgical center. (subject to *Inpatient* and *Day Surgery Copayment* Maximum)	40
Early Intervention Services **(PA), (BL)**	Deductible and coinsurance apply; no copayments apply .	41
Hemodialysis services	Deductible and coinsurance apply; no copayments apply .	41
Human leukocyte antigen testing or histocompatibility locus antigen testing **(PA)(BL)**	Deductible and coinsurance apply; no copayments apply .	41
Immunizations	*No deductible, coinsurance or* c*opayment apply*.	41
Infertility services **(PA), (BL)**	Deductible and coinsurance apply; no copayments apply .	42
Laboratory tests **(PA)**	Deductible and coinsurance apply; no copayments apply .	42

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Benefit Overview, continued
Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	**Your Cost**	**Page**
***Outpatient* Care, continued**		
Lead screenings	Deductible and coinsurance apply; no copayments apply .	43
Lyme disease	Deductible and coinsurance apply; no copayments apply .	43
Nutritional counseling **(PA)**	Deductible and coinsurance apply; no copayments apply .	43
Oral health services **(PA)**	Deductible and coinsurance apply; no copayments apply .	43
Outpatient free standing ambulatory surgi-center	Deductible and coinsurance apply; no copayments apply .	44
Outpatient surgery in a physicians office **(PA)**	Deductible and coinsurance apply; no copayments apply .	44
Podiatric services	*Copayment only applies*.	44
Preventive care	*No deductible, coinsurance or* co*payment apply*	44

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Benefit Overview, continued
Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	**Your Cost**	**Page**
Hearing examinations and screenings	Deductible and coinsurance apply; no copayments apply .	45
Prevention and early detection services **(BL)**	*No deductible, coinsurance or* co*payment apply*	45
Radiation Therapy	Deductible and coinsurance apply; no copayments apply	46
Respiratory therapy or pulmonary rehabilitation services **(PA)**	No deductible; copayment per visit applies.	46
Short term speech, physical and occupational therapy **(PA)**	No deductible; copayment per visit applies.	46
Smoking cessation counseling sessions	No deductible; copayment per visit applies.	46
Vision care **(PA), (BL)**	No deductible; copayment per visit applies	47

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Benefit Overview, continued
Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	**Your Cost**	**Page**
Inpatient care		
Hospital services **(PA)**	Deductible and coinsurance apply; no copayments apply	50
Reconstructive surgery and procedures and mastectomy surgeries **(PA)**	Deductible and coinsurance apply; no copayments apply	50
Skilled care in a nursing facility **(PA)**	Deductible and coinsurance apply; no copayments apply	51
Solid organ and hematopietic stem cell transplants **(PA)**	Deductible and coinsurance apply; no copayments apply	51
Maternity Care		
Maternity care – Outpatient **(PA)**	Deductible and coinsurance apply; no copayments apply	52
Maternity care – Inpatient **(PA)**	Deductible and coinsurance apply; no copayments apply	52

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Benefit Overview, continued
Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	Your Cost	Page
Behavioral Health Services for Mental Health Care		
Outpatient mental health care services **(PA)** required after the initial 12 encounters are used in a calendar year	Deductible and coinsurance apply; no copayments apply	53
Inpatient and intermediate mental health care services **(PA)**	Deductible and coinsurance apply; no copayments apply	55
Behavioral Health Services for Chemical Dependency		
Outpatient chemical dependency services **(PA)** required after the initial 12 encounters are used in a calendar year	Deductible and coinsurance apply; no copayments apply	55
Inpatient and intermediate chemical dependency services **(PA)**	Deductible and coinsurance apply; no copayments apply	55
Other Health Services		
Ambulance services **(PA)**	Deductible and coinsurance apply; no copayments apply	56
Clinical trials **(PA)**	Deductible and coinsurance apply; no copayments apply	56

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Benefit Overview, continued
Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	Your Cost	Page
Other health services continued		
Durable medical equipment **(PA)**	Deductible and coinsurance apply; no copayments apply	57
Hearing aids **(PA), (BL)**	Deductible and coinsurance apply; no copayments apply	58
Home health care **(PA)**	Deductible and coinsurance apply; no copayments apply	58
Hospice care services **(PA)**	Deductible and coinsurance apply; no copayments apply	59
Injectable, infused or inhaled medications **(PA)**	Deductible and coinsurance apply; no copayments apply	59
Medical supplies **(PA)**	Deductible and coinsurance apply; no copayments apply	60
New cancer therapies or other life threatening diseases or conditions **(PA)**	Deductible and coinsurance apply; no copayments apply	60
Orthoses and prosthetic devices **(PA), (BL)**	Deductible and coinsurance apply; no copayments apply	60
Special medical formulas **(PA)**	Deductible and coinsurance apply; no copayments apply	60

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Chapter 1. Getting started as a member

SECTION 1 Introduction

Welcome to Neighborhood Health Plan of Rhode Island ("Neighborhood"). We are pleased that you have selected us. We want to make sure you understand the information in this *Certificate of Coverage* and that you are satisfied with the services you receive as a Neighborhood member. Please call Neighborhood *Member Services* at 1-800-459-6019 (TTY 1-401-459-6690) if you have any questions about your benefits or visit us at www.nhpri.org.

Section 1.1 You are enrolled in Neighborhood Exchange Health Plan which is an HMO

There are different types of health plans. Neighborhood's Exchange Health Plan is an HMO Plan (HMO stands for Health Maintenance Organization). We arrange for your healthcare through a network of contracted healthcare professionals and facilities. You will need to choose a *Primary Care Provider* (*PCP*), who will be responsible for managing your care.

Section 1.2 What the Certificate of Coverage booklet is about

This *certificate of coverage* booklet tells you how to get your health plan benefits covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

This plan, Neighborhood Exchange Health Plan, is offered by Neighborhood. (When this *certificate of coverage* says "we," "us," or "our," it means Neighborhood. When it says "plan" or "our plan," it means NHPRI Exchange Health Plan.

The word "*coverage*" and "*covered services*" refers to the medical care and services available to you as a member of NHPRI Exchange Health Plan.

Section 1.3 What this chapter tells you

Look through Chapter 1 of this *Certificate of Coverage* to learn:

- What makes you eligible to be a plan member?
- What is your plan's service area?
- What materials will you get from us?
- How do you keep the information in your *Membership* record up to date?

Section 1.4 If you are new to NHPRI Exchange Health Plan

If you are a new member, then it's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Certificate of coverage* booklet.

If you are confused or concerned or just have a question, please contact our plan's *Member Services*

Section 1.5 Legal information about the Certificate of Coverage

This *Certificate of Coverage* is part of our contract with you about how NHPRI's Exchange Health Plan *covers* your care. Other parts of this contract include your enrollment form and any notices you receive from us about changes to your *coverage* or conditions that affect your *coverage*. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in NHPRI's Exchange Health Plan.

SECTION 2 What makes you eligible to be a plan member

Section 2.1 An eligible person

You: Any person is eligible as a *subscriber* to enroll in *coverage* under this agreement if you:

- Maintain primary residence in our service area, Rhode Island, and
- Live in Rhode Island for at least 9 months in each period of 12 months*

*Note: The 12-month period begins with the first month you do not live in Rhode Island.

Your *spouse* or *child* is eligible as a *dependent* only if you are a *subscriber* and that *spouse* or *child*:

- Qualifies as a *dependent* as defined in this *certificate of coverage*.
- Children are not required to maintain primary residence in Rhode Island. However, care outside of Rhode Island is limited to *emergency* or urgent care only.

<u>If you live outside the Service Area**</u>

If you live outside the Service Area, you can be *covered* only if:

- You are a *child*; or
- You are a *dependent* subject to the Qualified Medical Child Support Order (QMCSO); or
- You are a divorced *spouse* Neighborhood must *cover*.

**Note: Care outside of the Service Area of Rhode Island is limited to Emergency or Urgent Care only.

Your *spouse*: Your spouse is eligible to enroll for *coverage* under this agreement, if you have selected *family coverage*. Only one of the following individuals may be enrolled at a given time:

- Your opposite sex spouse, according to the statutes of the state in which you were married, when your marriage was formed by obtaining a marriage license, having a marriage ceremony, and registering the marriage with the appropriate state or local official.
- Your common law spouse, according to the law of the state in which your marriage was formed (generally, common law spouses are of the opposite-sex). Your spouse by common law of the opposite gender is eligible to enroll for *coverage* under this agreement. To be eligible, you and your common law spouse must complete and sign our Affidavit of Common Law Marriage and send us the necessary proof. Please call us to obtain the Affidavit of Common Law Marriage.
- Your same-sex spouse, according to the laws of the state in which you were married, when your marriage was formed by obtaining a marriage license, having a marriage ceremony, and registering the marriage with the appropriate state or local official. Your same-sex spouse may be enrolled only if your marriage is recognized by the state in which you reside.
- Your civil union partner, according to the law of the state in which you entered into a civil union. Civil Union partners may be enrolled only if civil unions are recognized by the state in which you reside.
- Former *spouse*: In the event of a divorce, your former spouse will continue to be eligible for *coverage* provided that your divorce decree requires you to maintain continuing *coverage* under a family policy in accordance with state law. In that case, your former spouse will remain eligible on your policy until the earlier of:

- The date either you or your former spouse are remarried;
- The date provided by the judgment for divorce; or
- The date your former spouse has comparable *coverage* available through his or her own employment.

Domestic Partner: Your domestic partner is eligible to enroll for coverage under this agreement. You and your domestic partner must complete and sign our Declaration of Domestic Partnership and we must receive necessary proof.

Your Children: Each of your and your spouse's children are eligible for coverage up to the maximum *dependent* age shown in the Summary of Benefits, or as ordered by a Qualified Medical Child Support Order ("QMCSO"). For purposes of determining eligibility under this agreement, the term *child* means:

- Natural Children;
- Step-children;
- Legally Adopted Children: In accordance with Rhode Island General Law § 27-20-14, an adopted *child* will be considered eligible for *coverage* as of the date of placement for adoption with you by a licensed child placement agency;
- Foster Children: Your foster children who permanently live in your home are eligible to enroll for *coverage* under this agreement.

***Disabled dependent*s:** In accordance with Rhode Island General Law § 27-20-45, when your unmarried *child* who is enrolled for *coverage* under this agreement reaches the maximum *dependent child* age and is no longer considered eligible for *coverage*, he or she continues to be an *eligible person* under this agreement if he or she is a *disabled dependent*.

If you have an unmarried *child* of any age who is medically certified as disabled and is chiefly dependent on you for support and care because of mental impairment or physical disability, which can be expected to result in death or can be expected to last for a continuous period of not less than twelve months, that *child* is an eligible *dependent* under this agreement. If you have a *child* whom you believe satisfies these conditions, you must call us to obtain the form necessary to verify the *child*'s disabled status and show proof of the disability. This form must be filled out and submitted to us. Periodically thereafter, you may be asked to show proof that this disabling condition still exists to maintain *coverage* as a *dependent* for this *child*.

<u>Proof of eligibility</u>

We may ask you for proof of your and your *dependent*s' eligibility or continuing eligibility. You must give us proof when asked. This may include proof of residence, marital status, birth or adoption of a *child*, and legal responsibility for health care *coverage*.

Section 2.2 When you may enroll

When first eligible

You and your eligible *dependent*s may enroll by making written application to us through the *Exchange*. So long as we receive your Membership application within that timeframe and your Membership fees are paid, your *coverage* begins on the first day of the month following your submission of a complete application to us.

Special Enrollment Period

Adding dependents under *family coverage*

After your initial *effective date*, you may enroll your eligible *dependent*s for *coverage* through a Special Enrollment Period after you or your eligible *dependent*s experience a change in family status, a loss of private health *coverage*, or a change in eligibility for Medicaid or a State Children's Health Insurance Program (CHIP) as described below.

With a change in family status, you must make written application within the thirty-one (31) days following the event. You and/or your eligible *dependent*s will qualify for a Special Enrollment Period as follows:

- If you get married, *coverage* begins the first day of the month following your marriage.
- If you have a *child* born to the family, *coverage* begins on the date of the *child*'s birth.

  You must notify Neighborhood of the birth of a newborn *child* and pay us the required Premium within 31 days after the date of birth. Otherwise, that *child* will not be *covered* beyond the 31-day period. No coverage is provided for a newborn *child* who remains hospitalized beyond that 31-day period and has not been enrolled in this plan.
- If you have a *child* placed for adoption with your family, *coverage* begins on the date the *child* is placed for adoption with your family.

  You must enroll your *Adoptive Child* within 31 days after the *child* has been adopted or placed for adoption with you. This is required for that *child* to be *covered* from the date

of his or her adoption. Otherwise, you must wait until the next Open Enrollment Period to enroll the *child*.

Late Enrollment

You and/or your eligible *dependent*s may enroll following the initial enrollment period, and outside of the open enrollment or special enrollment periods. *Coverage* is effective the first day of the calendar month following the receipt of your completed application.

With a loss of private health *coverage*, you must make written application within the thirty-one (31) days following the event. *Coverage* begins the first day of the month following the loss of private health coverage. If you or your eligible *dependent*s have a loss of coverage on the first day of the month, *coverage* under this plan begins on the first day of that month. You or your eligible *dependent*s will qualify for a Special Enrollment Period if each of the following conditions is met:

- The *eligible person* seeking *coverage* had other coverage at the time that he or she was first eligible for *coverage* under this agreement;
- The person waived *coverage* under this plan due to being *covered* on another plan; and
- The coverage on the other plan is terminated as a result of:
    - Loss of eligibility for the *coverage* (including as a result of legal separation, divorce, death,
    - Termination of employment, or a reduction in the number of hours of employment),
    - Employer contributions towards such *coverage* being terminated, or
    - *COBRA*, due to continuation, is exhausted.

With a change in eligibility for Medicaid or a CHIP, you must make written application within sixty (60) days following your change in eligibility. *Coverage* will begin on either the first day of the month following the event or, if the event occurs on the first day of a month, coverage under this plan begins on the first day of that month. You and/or your eligible *dependent*s will qualify for a Special Enrollment Period as follows:

- You and/or your eligible *dependent* are terminated from Medicaid or CHIP *coverage* due to a loss of eligibility; or

- You and/or your eligible *dependent* become eligible for premium assistance, coverage, through Medicaid or CHIP.

Coverage for Members who are hospitalized on their *effective date*

If you are in the hospital on your *effective date* of *coverage*, health care services related to such hospitalization are *covered* as long as: (a) you notify us of your hospitalization within forty-eight (48) hours of the *effective date*, or as soon as is reasonably possible; and (b) *covered services* are received in accordance with the terms, conditions, exclusions and limitations of this agreement. As always, benefits paid in such situations are subject to the coordination of benefits provisions described in Chapter 9 Section 5.

Section 2.3 Continuing eligibility for dependents

When does *coverage* end?

Dependent coverage for a *child* ends on the *child*'s 26th birthday.

This age limit does not apply to a *child* who qualifies as a *disabled dependent* at any age.

Section 2.4 Neighborhood's plan service area

Neighborhood's Plan is available only to individuals who live in our plan service area. To remain a member of our plan, you must keep living in this service area. The service area, which is also the enrollment service area, is the geographical area within which we have developed a network of *provider*s to afford Members with adequate access to *covered services*. The Enrollment Service Area consists of the entire state of Rhode Island.

If you plan to move out of the service area, please contact *Member Services*

SECTION 3 Other materials will you get from us

Section 3.1 Your plan membership identification card – use it to get all *covered* care

Neighborhood gives each *member* a member identification card (Member ID card). While you are a member of our plan, you must use your Membership card whenever you get any services covered by this plan.

Please check your Member ID card for accuracy.

When you receive your Member ID card, check it carefully. If any information is wrong, call *Member Services*.

Identifying yourself as a Neighborhood Member

Your Member ID card is important; it identifies you as a Neighborhood *member*. Please:

- Carry you Member ID card at all times
- Have your Member ID card with you for medical, hospital and other appointments, and
- Show you member ID card to any *provider* before you receive healthcare services

If your Member ID card is lost, damaged or stolen

If your plan Member ID Card is damaged, lost, or stolen, call *Member Services* right away and we will send you a new card.

Membership requirement

You are eligible for benefits if you are a *member* when you receive care. A Member ID card alone is not enough to get you benefits. If you receive care when you are not a *member*, you are responsible for the cost.

Section 3.2 The Provider Directory: your guide to all providers in the plan's network

Every year that you are a member of our plan, we will send you either a new *provider* Directory or an update to your *Provider* Directory. This directory lists our *network provider*s.

What are "*network provider*s"?

Network *provider*s are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan *cost sharing* as payment in full. We have arranged for these *provider*s to deliver *covered services* to Members in our plan.

Why do you need to know which *provider*s are part of our network?

It is important to know which *provider*s are part of our network because, with limited exceptions, while you are a member of our plan you must use *network provider*s to get your medical care and services. The only exceptions are emergencies, urgently needed care when

the network is not available (generally, when you are out of the area) and cases in which Neighborhood authorizes use of *out-of-network provider*s. See Chapter 3 (Using the plan's coverage for your medical services) for more specific information about *emergency*, *out-of-network*, and out-of-area coverage.

If you don't have your copy of the *Provider* Directory, you can request a copy from *Member Services* at 855-321-XCHG (855-321-9244). You may ask *Member Services* for more information about our *network provider*s, including their qualifications. Additionally, Neighborhood's *Provider* Directory is available online at **www.nhpri.org**. You will be able to search the online directory to find all of the primary care doctors (*PCP*s), specialty doctors, behavioral health doctors, hospitals and urgent centers that participate in our network. Both *Member Services* and the website can give you the most up-to-date information about changes in our *network provider*s.

SECTION 4 Keep your plan membership record up to date

Section 4.1 How to help make sure that we have accurate information about you

Your Membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your *Primary Care Provider* (*PCP*).

The doctors, hospitals, and other *provider*s in the plan's network need to have correct information about you. **These *network provider*s use your Membership record to know what services are covered and the cost-sharing amounts for you**. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, Medicare or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you receive care in an out-of-area or *out-of-network* hospital or emergency room
- If your authorized representative (such as a caregiver) changes

- If you are participating in a clinical research study

If any of this information changes, please let us know by calling *Member Services*.

SECTION 5 We protect the privacy of your personal health information

Section 5.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.5 of this booklet.

Chapter 2. Important phone numbers and resources

SECTION 1 NHPRI Exchange Health Plan contacts (how to contact us)

How to contact our plan's *Member Services*

The *Member Services* Department is available to help answer your questions. For assistance with:

- How the Plan works
- Selecting a *Primary Care Provider* (*PCP*)
- Benefits
- Enrollment, eligibility
- Network *provider* information
- Member ID Cards
- *Claim*s and payment requests
- Inquiries, *complaint*s and *appeal*s
- Status of utilization reviews

Please call or write to Neighborhood's *Member Services*. We will be happy to help you.

Member Services	
CALL	855-321-XCHG (855-321-9244) Calls to this number are free. Hours of Operations are Monday - Friday 8:30 am – 5:00 pm *Member Services* also has free language interpreter services available for non-English speakers.

TTY	401-459-6690 Calls to this number are free. Hours of Operations are Monday - Friday 8:30 am – 5:00 pm
WRITE	*Member Services* Neighborhood Health Plan of Rhode Island 299 Promenade St. Providence, RI 02908
WEBSITE	www.nhpri.org

SECTION 2 Emergency medical care

Emergency Medical Care

To obtain *emergency* medical care: In an *emergency* seek care at the nearest emergency facility. If needed call 911 for emergency medical assistance. If 911 services are not available in your area, call the local number for *emergency* services.

SECTION 3 Routine or urgent care

Routine or Urgent Care

To obtain routine or urgent medical care: For routine and urgent care in the service area, always call you *PCP*.

SECTION 4 Mental health and chemical dependency services

Mental health and chemical dependency services

To obtain mental health and chemical dependency services: The Plan contracts with Beacon Health Strategies, LLC, to manage all mental health and *chemical dependency* services. If you need these services, you may do any of the following:

- Call the toll-free 24-hour mental health / *chemical dependency* telephone line – staffed by Beacon at 1-800-215-0058 for help finding a *network provider*

- Go directly to a *network provider* who provides mental health or *chemical dependency* services
- Call your *PCP*
- Visit Beacon's website www://beaconhealthstrategies.com or follow the link on the Plan's website

Chapter 3. Using the plan's coverage for your medical services

SECTION 1 Things to know about getting your medical care and prescription drugs covered

This chapter explains what you need to know about using the plan to get your medical care covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by the plan.

For the details on what medical care and prescription drugs are covered by our plan and how much you pay when you get these services, use the benefits information in the next chapter, Chapter 4 Covered services).

Section 1.1 "Network providers" and "covered services"

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- "*Providers*" are doctors and other health care professionals licensed by the state to provide medical services and care. The term "*providers*" also includes hospitals and other health care facilities.

- "Network *providers*" are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these *providers* to deliver *covered services* to Members in our plan. The *providers* in our network generally bill us directly for care they give you. When you see a *network provider*, you usually pay only your share of the cost for their services.

- "*Covered services*" include all the medical care, health care services, medications, supplies, and equipment that are covered by our plan. Your *covered services* for medical care are listed in Chapter 4.

Section 1.2 Basic rules for getting your medical care covered

NHPRI Exchange Health Plan will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits** (reference Chapter 4 of this booklet).

- **The care you receive is considered *medically necessary***. "*Medically necessary*" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You have a network *Primary Care Provider* (a *PCP*) who is providing and overseeing your care.** As a member of our plan, you must choose a network *PCP* (for more information about this, see Section 2.1 in this chapter).

    - In most situations, your network *PCP* must give you approval in advance before you can use other *provider*s in the plan's network, such as specialists, hospitals, *skilled* nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about this, see Section 2.3 of this chapter.

    - Referrals from your *PCP* are not required for *emergency* care or urgently needed care. There are also some other kinds of care you can get without having approval in advance from your *PCP* (for more information about this, see Section 2.2 of this chapter).

- **You must receive your care from a *network provider*** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-*network provider* (a *provider* who is not part of our plan's network) will not be covered. Here are two exceptions:

    - The plan covers *emergency* care or urgently needed care that you get from an *out-of-network provider*. For more information about this, and to see what *emergency* or urgently needed care means, see Section 3 in this chapter.

    - If you need medical care our plan is required to cover and the *provider*s in our network cannot provide this care, you can get this care from an *out-of-network provider*. An authorization must be obtained from Neighborhood prior to seeking care. In this situation, you will pay the same as you would pay if you got the care from a *network provider*. For information about getting approval to see an *out-of-network* doctor, see Section 2.4 in this chapter.

Section 1.3 Preauthorization

Preauthorization is required for certain *covered services*. Services that require *preauthorization* are marked with an asterisk (*) in the Summary of Medical Benefits.

If a *preauthorization* is required, Neighborhood will make a decision as expeditiously as your health condition might require, but no later than fifteen (15) calendar days from the receipt of the request. This timeframe may be extended by fifteen (15) calendar days if you request

it or NHRPI determines there is a need for additional information and documents (for example medical evidence) and the delay is in your best interest.

Your *network provider* is responsible for obtaining *preauthorization* for in-network *covered services*. You must request approval from Neighborhood prior to scheduling an appointment or receiving *covered services* from *non-network provider*s, by calling *Member Services* at 1-866-423-0945. Neighborhood's Medical Management Department will review your request for services.

Fast (expedited) *Preauthorization* Review

You may request an fast *preauthorization* review. NHRPI will expedite the request based on either of the following conditions:

- We find that applying the standard time for making a determination could seriously jeopardize your health, life, or ability to regain maximum function; or
- Your physician indicates, either orally or in writing, that applying the standard time for making a determination could seriously jeopardize your life or ability to regain maximum function.

Neighborhood will make a decision as expeditiously as your health condition might require, but no later than 72 hours after receipt of the request. This timeframe may be extended by fifteen (15) calendar days if you request it or NHRPI determines there is a need for additional information and documents (for example medical evidence) and the delay is in your best interest.

Prescription Drug *Preauthorization*

Prescription drugs for which *preauthorization* is required are marked with "PA" on the list of covered drugs on Neighborhood's website (www.nhpri,org)

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

- Preauthorization requests are reviewed by our Pharmacist and Physician Reviewer within 14 calendar days from the date when the request is received. If the preauthorization request is denied we send you written notification within 14 calendar days from the date when the request is received. If the preauthorization is approved we will notify your prescriber and Pharmacist via fax.

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

SECTION 2 Use providers in the plan's network to get your medical care

Section 2.1 You choose a Primary Care Provider (PCP) to provide and oversee your medical care

What is a "*PCP*" and what does the *PCP* do for you?

A primary care doctor is called a "*PCP*", which stands for "primary care physician or *provider*." You must choose a *PCP* when you enroll with NHRPI. Your *PCP*'s name and phone number will be on your Neighborhood Member ID card. Your *PCP* is the doctor who knows you best. Your *PCP* wants to keep you healthy. Be sure to tell him or her about your medical concerns, visits to other doctors, trips to the hospital or ER, and any injuries or sicknesses you experience.

You can call your doctor's office 24 hours a day, seven days a week. Someone will be there to help you get the care you need. If no one can take your call at your doctor's office, there will be an answering service or an answering machine. It will provide instructions for emergencies, instructions for leaving a message, directions for reaching your doctor, and/or a referral to another doctor who can help you. Your *PCP* will coordinate your care by treating you or referring you to specialty services.

Your *PCP* will:

- Help you decide what to do when you or your *child* has a medical problem;
- Provide routine care;
- Give you annual checkups, vaccinations and sees you for other visits;
- Coordinate your health care services and visits to other doctors;
- Order prescriptions or tests for you; and
- Give you advice and answer questions about your health care.

What are the Different Types of *PCP*s You May Choose From?

Family Doctor: A family doctor treats patients of all ages. A family doctor provides *preventive care* (immunizations and check-ups), care for acute and chronic illnesses (such as asthma and diabetes), and health education. Some family doctors also take care of prenatal patients and deliver babies.

Internal Medicine Doctor: Internal medicine doctors diagnose and treat the diseases that affect the body's organs or the body as a whole. A doctor who practices internal medicine is also sometimes called an internist. Internal medicine doctors care for adult patients.

Pediatrician: A pediatrician provides care to babies, children, and teenagers.

Nurse Practitioner: A registered nurse who is qualified to conduct physical examinations, select plans of treatment, order appropriate laboratory tests/procedures), prescribe medications, coordinate consultations and referrals, and provide health education.

OB/GYN: A doctor who specializes in the care of women. This includes pregnant women, women's reproductive organs, breasts, and sexual function. Your OB-GYN may also offer primary care services.

How do you choose your *PCP*?

You should choose a *PCP* from Neighborhood's *Provider* Directory. Our *Provider* Directory will tell you where the doctor's office is located, what languages he or she speaks, and what hours the office is open. You may want to consider one that is close to home, or is recommended by a friend. You may also refer to our website at www.nhpri.org to find out this information as well.

- You may already have a *provider* who is listed as a *PCP* in our directory. In most instances you may choose him or her as your *PCP*. Once you choose a *PCP* in our network, you must inform us of your choice.

- You may not have a *PCP* or your *provider* may not be listed in our *Provider* Directory. In either case, you may also call *Member Services* for help in choosing a *PCP*.

Contacting your new *PCP*

If you choose a new *provider* as your *PCP*, you should: •

- Contact your new *PCP* as soon as you join;

- Identify yourself as a new Neighborhood Plan *member*, to him or her;

- Ask your previous *provider* to transfer your medical records to your new *PCP*; and
- Make an appointment for a check-up or to meet your *PCP*.

Changing your *PCP*

You may change your *PCP* or your *child*'s primary care doctor for any reason, at any time. Also, it's possible that your *PCP* might leave our plan's network of *provider*s and you would have to find a new *PCP*.

For a list of all primary care doctors in the Neighborhood Network, visit our website at www.nhpri.org. You can also request a copy of this information by calling *Member Services* at 1-800-459-6019.

Please call Neighborhood's *Member Services* for assistance if the primary care doctor listed on your member ID card or your *child*'s card is not correct, or if you would like to choose another primary care doctor for you or your *child*.

What happens if your *PCP* leaves the Neighborhood network?

We will send you a letter to inform you of this change. You can choose another *PCP* from the Neighborhood network or you will be assigned to one near your home. Please call Neighborhood *Member Services* at 855-321-XCHG (855-321-9244) if you need help choosing a new *PCP*.

Section 2.2 The kinds of medical care can you get without getting approval in advance from your *PCP*

A self-referral is when you make an appointment at a specialty care office without talking with your *PCP* first. If you self-refer to a specialist's office, choose a doctor who is in Neighborhood's *provider* network. Make sure you tell your *PCP* about the visit. Below are doctors you can make an appointment with or obtain services from without getting approval in advance from your *PCP* or Neighborhood.

- *Emergency* services from *network provider*s or from *out-of-network provider*s - both in Rhode Island and outside of Rhode Island. (Note: if admitted as an *inpatient*, you or someone acting for you should call your *PCP* or Neighborhood within 48 hours of receiving care).
- Urgently needed care services at a facility or walk in clinic - from in-*network provider*s or from *out-of-network provider*s when *network provider*s are temporarily unavailable or inaccessible; for example when you are temporarily outside of the plan's service area.

(Note: You must contact your *PCP* for follow up care after urgent care *covered services* are rendered.)

- Obstetric (pregnancy) / gynecological (women's care): routine visits, exams and *medically necessary* follow-up care and services
- Behavioral health services (mental health and *chemical dependency* services)
- Family planning, counseling, or birth control visits
- Routine eye exams every
- Diabetic eye exam (every year)
- Childbirth education and parenting classes
- Smoking cessation programs to help you quit
- Sexually transmitted disease (STD) treatment through the RI Department of Health

Section 2.3 Getting care from specialists and other network providers

A specialty care doctor, or specialist, is a doctor who cares for a specific part of the body or for a specific disease. Specialty care doctors have extra training /education about that area of the body or that disease. Your primary care doctor (*PCP*) is responsible for your regular care and checkups. He or she helps you see a specialist when you need one.

Some examples of specialty doctors include:

- **Obstetrician / gynecologist**: An obstetrician / gynecologist is a doctor who provides women's medical care, diagnosis, and treatment of disorders in the female reproductive system, and provides care for pregnant women.
- **Gynecologist**: A gynecologist diagnoses and treats diseases of the female reproductive system.
- **Obstetrician**: An obstetrician cares for women who are pregnant and delivers babies.
- **Podiatrist**: A podiatrist is a physician that specializes in the evaluation and treatment of diseases of the foot.
- **Optometrist**: An optometrist is a health care professional who is licensed to provide eye care services.

- **Ophthalmologist**: A medical doctor specializing in the treatment of diseases of the eye.
- **Endocrinologist**: A medical doctor who specializes in the diagnosis and treatment of disorder of the glands, for example, diabetes or thyroid disorders.
- **Women's health specialist**: A medical doctor or practitioner specializing in the treatment of women's health needs, including family planning. Women's health specialists include, but are not limited to, obstetricians, gynecologists, and certified nurse midwives.
- **Oncologists**: An oncologist cares for patients with cancer.
- **Cardiologists**: A medical doctor specializing in the care of patients with heart conditions.
- **Orthopedists**: An orthopedist cares for patients with certain bone, joint, or muscle conditions.

What is a referral?

Your primary care doctor (*PCP*) may decide you should see a specialist. He or she will give you a referral. A referral means your doctor recommends this specialist to diagnose and treat your condition. Your primary care doctor (*PCP*) will contact the specialist and let that office know you will be scheduling an appointment. Make sure you give your doctor enough time to call the specialist before you make an appointment. Sometimes—but not very often—you will need approval from Neighborhood before seeing a specialist. After your doctor recommends a specialist, the specialist will contact Neighborhood to get permission to care for you.

What if a specialist or another *network provider* leaves our plan?

Sometimes a specialist, clinic, hospital or other *network provider* you are using might leave the plan. Our Neighborhood *Member Services* Specialists will help you with selecting another *provider*.

In special circumstances, Neighborhood will temporarily allow you to continue receiving services and care from your *PCP* or specialty care doctor even if she or he leaves our *provider* network. Some special cases might be if you are being treated for an ongoing condition or if you are pregnant. This is because your relationship with your doctor is important. We will work with you and your doctor to ensure a safe and comfortable transition of your health care to another doctor. Please call Neighborhood *Member Services* at 855-321-XCHG (855-321-9244) if your *provider* decides to leave our network and you need to continue to seeing him or her for a while.

Section 2.4 Getting care from out-of-network providers

You might need health care services when you are "out of area". This means you are too far away to receive care from a doctor or hospital in Neighborhood's network. *Emergency* services are always covered when you are out of area. If you are experiencing an *emergency* call 911 immediately or visit the nearest emergency room. Call your primary care doctor when you return home to tell them what happened. If you received a bill for *emergency* services you received out of area, send it to Neighborhood's *Member Services* department.

All other covered health care services, care and services provided "out of area" need to be approved by Neighborhood by first calling *Member Services* at 855-321-XCHG (855-321-9244).

Sometimes you may need care from a local doctor who is not in Neighborhood's *provider* network. This doctor is "out of network". To see an "out of network" doctor, you'll need approval from Neighborhood before you make the appointment by calling Neighborhood *Member Services* at 855-321-XCHG (855-321-9244). If you do not receive approval to see and "out of network" provider you will be responsible for the cost of services.

Requests for services for non-*emergency* care from doctors who are not in NNPRI's network are considered if one (1) of the following are met:

- The services requested are not available in Neighborhood's network.
- Doctors with the same expertise are not available in Neighborhood's network.
- You are getting treatment for an acute medical condition, a chronic condition, or are in your 2nd or 3rd trimester of pregnancy and your doctor leaves the Neighborhood network.
- You are getting follow up care from *emergency* services.
- You have an ongoing relationship with a primary care or specialty care doctor.

Neighborhood's Medical Management team will make a decision within 15 calendar days from when the request for an *out-of-network* service is received. If more information is needed to help Neighborhood make a care decision, you will be notified that the decision timeframe has been extended. Requests for *out-of-network* services that are urgent are responded to within 72 hours.

You may request an fast *preauthorization* review for out-of-network services. NHRPI will expedite the request based on either of the following conditions:

- We find that applying the standard time for making a determination could seriously jeopardize your health, life, or ability to regain maximum function; or

- Your physician indicates, either orally or in writing, that applying the standard time for making a determination could seriously jeopardize your life or ability to regain maximum function.

Neighborhood will make a decision as expeditiously as your health condition might require, but no later than 72 hours after receipt of the request.

If you receive *covered services* from a doctor who is not in our network and you do not get approval from Neighborhood first, you may have to pay for the services. *Covered services* provided by non-Neighborhood Plan *provider*s are not paid for unless approved by Neighborhood before you make the appointment or receive the service. Contact Member Services. Our Medical Management team will review your request.

SECTION 3 Getting covered services when you have an emergency or urgent need for care

Section 3.1 Getting care if you have a medical emergency

What is a "medical *emergency*" and what should you do if you have one?

An "***emergency* medical condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition:

- Placing the health of the individual, or with respect to a pregnant woman her unborn *child* in serious jeopardy;

- Constituting a serious impairment to bodily functions; or

- Constituting a serious dysfunction of any bodily organ or part.

The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Examples of some types of emergencies are:

- Broken bones

- Poisoning or swallowing a dangerous substance

- Drug overdose
- Very bad pain or pressure
- Bleeding that will not stop
- Severe trouble breathing
- Change in level of consciousness
- Bad head injury
- Seizures (or a change in pattern of seizures)
- Complications of pregnancy such as persistent bleeding or severe pain
- Thoughts of Suicide

If you have a medical *emergency*:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do not need to get approval or a referral first from your *PCP*. The hospital does not need to be part of Neighborhood's network.
- **You may need to receive services in the hospital once your *emergency* condition has been taken care of.** These are call post stabilization services or care and services given to you to make sure another *emergency* does not happened. Your doctor will make sure you receive the care you need so that you can safely return home. Call your *PCP* within 48 hours to tell him/ her about your *emergency* visit.
- **As soon as possible, make sure that our plan has been told about your *emergency*.** We need to follow up on your *emergency* care. You or someone else should call to tell us about your *emergency* care, usually within 48 hours. Call our *Member Services* Department at 855-321-XCHG (855-321-9244).

What is covered if you have a medical *emergency*?

You may get covered *emergency* medical care whenever you need it, anywhere in the United States and territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits description in Chapter 4 of this booklet.

If you have an *emergency*, we will talk with the doctors who are giving you *emergency* care to help manage and follow up on your care. The doctors who are giving you *emergency* care will decide when your condition is stable and the medical *emergency* is over.

After the *emergency* is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your *emergency* care is provided by *out-of-network provider*s, we will try to arrange for *network provider*s to take over your care as soon as your medical condition and the circumstances allow.

We may not cover continued out of-network services after the *emergency* condition is treated and stabilized. This may happen if we determine, in coordination with the *member*'s *provider*s, that the *member* is safe for transport back into the Service Area and that transport is appropriate and cost-effective.

What if it wasn't a medical *emergency*?

Sometimes it can be hard to know if you have a medical *emergency*. For example, you might go in for *emergency* care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical *emergency* after all. If it turns out that it was not an *emergency*, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was not an *emergency*, we will cover additional care only if you get the additional care in one of these two ways:

- You go to a *network provider* to get the additional care, or
- The additional care you get is considered "urgently needed care" and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

Section 3.2 Getting care when you have an urgent need for care

What is "urgently needed care"?

"Urgently needed care" is a non-*emergency*, unforeseen medical illness, injury, or condition, that requires immediate medical care. Urgently needed care may be furnished by in-*network provider*s or by *out-of-network provider*s when *network provider*s are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in the plan's service area when you have an urgent need for care?

In most situations, if you are in the plan's service area, we will cover urgently needed care only if you get this care from a *network provider* and follow the other rules described earlier in this chapter. However, if the circumstances are unusual or extraordinary, and *network provider*s are temporarily unavailable or inaccessible, we will cover urgently needed care that you get from an *out-of-network provider*.

If you or your *child* needs urgent care, call your primary care doctor's office. Say you need to schedule a "sick visit." Your doctor should give you an appointment within 24 hours, or, he or she will direct you to an urgent care center in Neighborhood's network. Urgent care sites are helpful when you have a problem that needs to be seen that day but your doctor's office cannot give you an appointment. Here are some examples of problems that need urgent care:

- A sore throat
- Skin rash
- Pink eye
- Low grade fever
- Ear infection
- Mild or moderate trouble breathing
- Runny nose
- Coughing
- Persistent diarrhea

For more information about urgent care centers in your community, search the Neighborhood *Provider* Directory online at www.nhpri.org or call Neighborhood *Member Services* at 855-321-XCHG (855-321-9244)

What if you are <u>outside</u> the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a *network provider*, our plan will cover urgently needed care that you get from any *provider*. If this happens, we recommend that you or someone acting for you contact your *PCP*. You need to do this to arrange for any necessary follow-up care.

We may not cover continued services after the Urgent condition is treated and stabilized. This may happen if we determine, in coordination with the *member*'s *provider*s, that: (1) the *member* is safe for transport back into the Service Area; and: (2) that transport is appropriate and cost-effective

Our plan does not cover urgently needed care or any other care if you receive the care outside of the United States.

SECTION 4 If you are billed directly for the full cost of your covered services

Section 4.1 You can ask us to pay our share of the cost of covered services

If a doctor or hospital sends you a bill or if you paid for *covered services*, Neighborhood will help you resolve the issue. Neighborhood will pay you back when appropriate. To better help you, please make sure you let Neighborhood know as soon as you receive any bill. You can send the receipts to:

Member Services
Neighborhood Health Plan of Rhode Island
299 Promenade Street
Providence, RI 02908

This includes *emergency* services received out-of-area.

Section 4.2 If services are not covered by our plan, you must pay the full cost

NHPRI's Exchange Health Plan covers all medical services that are *medically necessary*, are listed in the plan's Medical and Pharmacy Benefits Description (this is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan *covered services*, or they were obtained *out-of-network* and were not authorized.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. If we say we will not cover your services, you have the right to *appeal* our decision not to cover your care.

Chapter 7 (What to do if you have a problem or complaint (coverage decisions, *appeal*s, *complaint*s) has more information about what to do if you want a coverage decision from us or want to *appeal* a decision we have already made. You may also call *Member Services* to get more information about how to do this.

For *covered services* that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. Funds used by a member to pay for services after a benefit limitation has been reached do not count towards the Out-of-Pocket Maximum. Instead, the member is responsible for the full cost of the services not subject to any maximum amount.

You can call *Member Services* when you want to know how much of your benefit limit you have already used.

Chapter 4. Covered health care services

SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter focuses on your *covered services* and what you pay for your medical benefits. It includes a list of *covered services* as a member of NHPRI Exchange Health Plan. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of *out-of-pocket* costs you may pay for your *covered services*.

- The **"*deductible*"** is the amount you must pay for medical services before our plan begins to pay its share.
- A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a *copayment* at the time you get the medical service.
- **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a *coinsurance* at the time you get the medical service.

Section 1.2 Your yearly plan deductible

An **individual *deductible*** of [$260-$3,250] per member per *contract year* applies to each *member* for *covered services* received (Medical $250-$3,000 and Pharmacy $10-$250)

A **family *deductible*** of [$520-$6,500] per family per *contract year* applies for all enrolled Members of a family for *covered services* received (Medical $500-$6,000 and Pharmacy $20-$500)

Your *deductible* is the amount you have to pay *out-of-pocket* before we will pay our share for your covered medical services.

Until you have paid the *deductible* amount, you must pay the full cost of your *covered services*. Once you have paid your *deductible*, we will begin to pay our share of the costs for covered medical services and you will pay your share, including your *copayment* or *coinsurance* amount, for the rest of the calendar year.

All amounts any enrolled Members in a family pay toward their individual *deductible*s are applied toward the family *deductible*.

Once the family *deductible* has been met during a *contract year*, all enrolled Members in a family will thereafter have satisfied their individual *deductible*s for the remainder of that *contract year*.

Please note that any amount paid by the *member* for a *covered service* rendered during the last 3 months of a *contract year* will be carried forward to the next *contract year*'s *deductible*.

The *deductible* does not apply to some services. This means that we will pay our share of the costs for these services even if you have not paid your yearly *deductible* yet. The *deductible* does not apply to the following services:

- Mental Health services in a *provider*'s office or in your home
- Outpatient cardiac *rehabilitation*
- Diabetic podiatric office visits
- Diagnostic hearing tests
- Emergency room services
- House calls
- Asthma education visits
- Hospital based clinic visits
- Office visits
- Pediatric office visits
- Podiatrist services
- Adult immunizations
- Smoking cessation counseling
- Vision care services
- *Chemical dependency* treatment in a *provider*'s office or in your home
- Chiropractic medicine
- Diabetic vision care services
- Early intervention services
- Hemophilia services in a doctor's office
- Allergist and dermatologist visits
- Diabetes education
- Nutritional counseling
- Specialist visits
- Urgent care visits
- Prevention and early detection services
- Pediatric immunizations
- Surgery in a doctor's office

Section 1.3 The most you will pay for covered medical services

Out-of-Pocket Maximum (Individual)

This *Certificate of Coverage* has an individual *out-of-pocket maximum* of [$850-$6,000] per member per *contract year* for all *covered services*. Only copayments, *deductible*s, and *coinsurance* count toward the *out-of-pocket maximum* (Medical $750-$5,000 and Dental $100-$1,000)

Out-of-Pocket Maximum (Family)

The family *out-of-pocket maximum* of [$1,700-$12,000] is satisfied in a *contract year* by adding the amount of covered health care expenses applied to the out-of- pocket maximum for all family members (Medical $1,500-$10,000 and Pharmacy $200-$2,000)

No one (1) family member can contribute more than [$850-$6,000] towards the *contract year* family out-of- pocket maximum (Medical $750-$5,000 and Pharmacy $100-$1,000)

All amounts any enrolled Members in a family pay toward their Individual *out-of-pocket maximum*s are applied toward the [$1,700-$12,000] family *out-of-pocket maximum* (Medical $1,500-$10,000 and Pharmacy $200-$2,000)

Once the family *out-of-pocket maximum* has been met during a *contract year*, all enrolled Members in a family will have satisfied their $850-$6,000] individual *out-of-pocket maximum*s for the remainder of that *contract year* (Medical $750-$5,000 and Pharmacy $100-$1,000)

Section 1.4 Our plan does not allow providers to "balance bill" you

As a member of NHPRI Exchange Health Plan, an important protection for you is that after you meet any *deductible*s, you only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow *provider*s to add additional separate charges, called "*balance billing*." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the *provider* less than the *provider charges* for a service and even if there is a dispute and we do not pay certain *provider* charges.

Here is how this protection works.

If your *cost sharing* is a *copayment* (a set amount of dollars, for example, $15.00), then you pay only that amount for any *covered services* from a *network provider*.

If your *cost sharing* is a *coinsurance* (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of *provider* you see:

- If you receive the *covered services* from a *network provider*, you pay the *coinsurance* percentage multiplied by the plan's reimbursement rate (as determined in the contract between the *provider* and the plan).

- If you receive the *covered services* from an *out-of-network provider*, you pay the *coinsurance* percentage multiplied by the plan's reimbursement rate for *out-of-network*

*provider*s. (Remember, the plan covers services from *out-of-network provider*s only in certain situations, such as in an *emergency* or when you get a referral to a *provider* for services not able to be provided in the network.)

SECTION 2 Medical benefits

Section 2.1 Your medical benefits

The Medical Benefits on the following pages lists the services NHPRI Exchange Health Plan covers and what you pay *out-of-pocket* for each service. Health care services and supplies are *covered services* only when the following requirements are met:

- They are listed as *covered services* in this chapter and are consistent with applicable state or federal law;
- Your *covered services* must be provided according to the coverage guidelines established by Neighborhood and in effect at the time the services or supplies are provided.
- Your services (including medical care, services, medications, supplies, and equipment) must be *medically necessary*. "*Medically necessary*" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- Services are obtained within the 50 United States and territories. The only exceptions to this rule are *emergency* care services or urgent care services while traveling, which are *covered services* when provided outside of the 50 United States.
- You receive your care from a *network provider*. In most cases, care you receive from an *out-of-network provider* will not be covered. Chapter 3 provides more information about requirements for using *network provider*s and the situations when we will cover services from an *out-of-network provider*.
- You have a *Primary Care Provider* (a *PCP*) who is providing and overseeing your care. In most situations, your *PCP* must give you approval in advance before you can see other *provider*s in the plan's network. This is called giving you a "referral." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Medical Benefits section are covered only if your doctor or other *network provider* gets approval in advance (sometimes called

"*preauthorization*") from us. *Covered services* that need approval in advance are marked in the Summary of Medical Benefits section by a footnote [Insert if applicable: In addition, the following services not listed require *preauthorization*: [insert list]].

- For all preventive services, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a *copayment* will apply for the care received for the existing medical condition.

Important Notes:

A covered service is one which is described in this chapter. We will only pay *claim*s that are for *covered services*.

Pre authorization is required for certain *covered services*. We only cover a service listed in this *Certificate* if we or our designee determine that the care is *medically necessary*.

- For services you receive in-network, your *network provider* is responsible for obtaining pre authorization.

- For services you receive from a *non-network provider*, you must obtain the *preauthorization* by contacting Neighborhood *Member Services*. The only exceptions are emergencies (in or out of the service area) and urgently needed care when the network is not available (generally, when you are out of the service area.)

Covered Services

The following section describes services that qualify as *covered services*.

For information about your costs for the *covered services* listed below (for example, copayments, coinsurance, deductibles and *out-of-pocket maximum*s), see the "Summary of Benefits" section in this *Certificate*.

Please note that your coverage level under this plan will be different for preventive services and diagnostic services:

Preventive care services described in the PPACA guidelines, including women's preventive health services and preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms are covered in full.

You may need to pay a *cost sharing* amount for diagnostic procedures (including diagnostic colonoscopies, endoscopies, and proctosigmoidoscopies) and diagnostic mammograms.

The Summary of Benefits lists information about the day, dollar, and visit limits under this plan. Certain limits are also included in some *covered services* listed below.

Emergency care

Services that are required to stabilize or start treatment for an *emergency* in an emergency room or in a physician's office are covered.

Benefits include the facility charge, supplies and all professional services.

You may receive *emergency covered services* from a *non-network provider*. In this case, Neighborhood will pay up to the reasonable charge.

The emergency room *copayment* is waived if the emergency room visit results in hospitalization within 24 hours.

Outpatient care

Allergy testing

Allergy testing (including antigens) and treatment, and allergy injections are covered.

Cardiac *rehabilitation* services Cardiac *rehabilitation* services

Outpatient treatment of documented cardiovascular disease is covered.

We cover only the following services:

- The *outpatient* convalescent phase of the *rehabilitation* program following hospital discharge; and
- The *outpatient* phase of the program that addresses multiple risk reduction, adjustment to illness and therapeutic exercise.

We do not cover the program phase that maintains rehabilitated cardiovascular health.

The benefit is limited to up to 24 weeks based on medical necessity.

Chemotherapy

Chiropractic

Chiropractic treatment is covered to restore or improve motion, reduce pain and improve function in a neuromusculoskeletal condition.

The benefit is limited to 12 visits per *contract year*.

Contraceptive Services

Coverage is provided for *outpatient* contraceptive services, in accordance with RI General Law §27-20-43. This includes consultations, procedures and medical services. These services must be related to the use of all contraceptive methods approved by the United States Food and Drug Administration.

Procedures include sterilization.

Covered services include:

- Medical examinations;
- Birth control counseling;
- Consultations;
- Genetic counseling.

Covered contraceptives include*

- Cervical caps;
- Implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants);
- Intrauterine devices (IUDs);
- Depo-Provera or its generic equivalent;
- Any other *Medically necessary* contraceptive device approved by the United States Food and Drug Administration.

* We cover certain contraceptives under a Prescription Drug Benefit. Those contraceptives include oral contraceptives and diaphragms. If those contraceptives are covered under that benefit, they are not covered here.

Diabetes Services and Supplies

In accordance with Rhode Island General Law § 27-18-38, coverage is provided for the following services and supplies for the treatment of insulin treated diabetes, non-insulin treated diabetes, or gestational diabetes, when *medically necessary* and prescribed by a physician:

- Blood glucose monitors and blood glucose monitors for the legally blind and therapeutic/ molded shoes for the prevention of amputation are covered as *Durable Medical Equipment*;
- Insulin pumps and related supplies and insulin infusion devices are covered as Medical Supplies.
- Test strips for glucose monitors insulin, insulin syringes and oral agents for controlling blood sugar that are included on our list of covered drugs are covered under your Prescription Drug Benefit (for a list of covered drugs go to www.nhpri.org or call our Member Services representative at 855-321-XCHG (855-321-9244); and

Diabetes self-management education, including medical nutrition therapy is also covered. This coverage for self-management education and education relating to medical nutrition therapy is limited to *medically necessary* visits upon the diagnosis of diabetes, where a physician diagnoses a significant change in the *member*'s symptoms or conditions which necessitate changes in a *member*'s self-management, or where reeducation or refresher training is necessary. This education, when *medically necessary* and prescribed by a physician, may be provided only by the physician or, upon his or her referral to an appropriately licensed and certified health care *provider* and may be conducted in group settings.

Coverage for self-management education and education relating to medical nutrition therapy may also include home visits when *medically necessary*.

Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care for Members with diabetes.

Upon the approval of the United States Food and Drug Administration, new or improved diabetes equipment and supplies will be covered when *medically necessary* and prescribed by a physician.

Diagnostic imaging

Coverage includes general imaging (such as x-rays and ultrasounds) and MRI/ MRA, CT/ CTA, and PET tests and nuclear cardiology.

Early intervention services

In accordance with RI General Law § 27-20-50, Preventive and primary services for a *Dependent child* younger than three years of age who is certified by the Rhode Island Department of Human Services as eligible for early intervention services are covered.

Early intervention services must be provided by a licensed *provider* designated by the Department of Human Services as an "early intervention *provider*" and who works in early intervention programs approved by the Department of Health.

Covered services include, but are not limited to:

- Evaluation and case management;
- Nursing care,
- Occupational therapy,
- Physical therapy,
- Speech and language therapy,
- Nutrition;
- Service plan development and review; and
- Assistive technology services and devices consistent with early intervention programs approved by the Department of Health.

Coverage limited to a benefit of five thousand dollars ($5,000) per dependent child per policy or calendar year.

Hemodialysis Services

Outpatient hemodialysis and peritoneal dialysis, including home dialysis are covered.

Human leukocyte antigen testing or histocompatibility locus antigen testing

In accordance with RI General Law § 27-20-36, testing is covered when it is necessary to establish a *member*'s bone marrow transplant donor suitability. Coverage includes the costs of testing for A, B or DR antigens. Testing must be performed at a facility accredited by the American Association of Blood Banks or its successors. At the time of the testing, the tested person must complete and sign an informed consent form that also authorizes use of the results of the test for participation in the National Marrow Donor Program.

Coverage limited to one test per lifetime for each subscriber.

Immunizations

We cover preventive vaccinations and immunizations in accordance with current guidelines. These guidelines are subject to change. Our allowance includes the administration and the vaccine.

If any of the above immunizations are provided as part of an office visit, only your office visit *copayment* and *deductible* (if any) will be applied.

Infertility services

In accordance with Rhode Island General Law § 27-18-30, coverage is provided for *medically necessary* diagnosis and treatment of infertility. We only cover these services for a woman who is:

- Between the ages of 25 and 42;
- Married, in accordance to the laws of the state in which she resides;
- Unable to conceive or sustain a pregnancy during a period of one year; and
- A presumably healthy individual.

Procedures are covered for the diagnosis and treatment of infertility to the extent that they are used in the diagnosis or treatment of conditions other than infertility.

Oral and injectable drug therapies may be used to treat infertility. These therapies are covered under your Prescription Drug Benefit.

Covered infertility procedures are covered up to a lifetime maximum of $100,000.

Laboratory tests

Covered laboratory tests include, but are not limited to blood tests, urinalysis, throat cultures, glycosolated hemoglobin (A1c) tests, genetic testing, and urinary protein/microalbumin and lipid profiles.

Laboratory tests must be ordered by a physician, physician assistant, or nurse practitioner. The lab tests must also be performed at a licensed laboratory.

Covered laboratory tests are not subject to the *deductible* when associated with routine *preventive care*.

Lead screenings

Lead screening related services, and diagnostic evaluations for lead poisoning are covered in accordance with Rhode Island law.

Lyme disease

Medically necessary diagnostic testing and long-term antibiotic treatment of chronic Lyme disease are covered when ordered by a physician after a thorough evaluation of the patient's symptoms, diagnostic test results and response to treatment. Treatment otherwise eligible for benefits will not be denied solely because it may be considered as unproven, *experimental*, or investigational, in accordance with Rhode Island General Law §27-18-62.

Nutritional counseling

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

Oral health services

The following oral services are covered. If you want to make sure that a planned service is a covered service, call *Member Services*.

Emergency care

X-rays and *emergency* oral surgery in a physician’s office or emergency room must be done to temporarily stabilize damaged tissues or reposition sound, natural and permanent teeth that have moved or have broken due to injury. You must receive this care within 48 hours after the injury. The injury must have been caused by a source outside the mouth.

Non-Emergency Hospital, physician, and surgical charges for the following conditions:

- Surgical treatment of skeletal jaw deformities; or
- Surgical treatment for Temporomandibular Joint Disorder (TMJ).
- In certain specific instances, the costs of *inpatient* services and day surgery for certain additional oral health services are covered.

Outpatient *free- standing ambulatory surgi-center*

Outpatient surgery done under anesthesia in an operating room of a facility licensed to perform surgery is covered. You must be expected to be discharged the same day and be shown on the facility's census as an *outpatient*.

Outpatient surgery in a physician's office

Podiatrist Services

Office visits to the podiatrist are covered.

Routine foot care is not covered. Routine foot care includes the treatment of corns, bunions (except capsular or bone surgery) calluses, the trimming of nails, the treatment of simple ingrown nails and other preventive hygienic procedures, except when performed to treat diabetic related nerve and circulation disorders of the feet.

Corrective or orthopedic shoes and orthotic devices used in connection with footwear are only covered for the treatment of diabetes.

The treatment of flat feet is not covered unless the treatment is surgical.

Preventive care for Members through age 19

Pediatric *preventive care* coverage for a *child* from birth to age 19 is provided in accordance with the American Academy of Pediatrics guidelines and as required by Rhode Island General Laws Section § 27-38.1.

Any *medically necessary* follow-up care as a result of a routine physical exam is subject to a *cost sharing* amount.

Preventive care for Members age 20 and over

Routine physical examinations including appropriate immunizations and lab tests as recommended by a *provider*;

Routine annual gynecological exam, including any *medically necessary* follow-up obstetric or gynecological care based on that exam;

- Per Rhode Island General Laws Section §27-41-45 women may receive an annual visit to an in-network obstetrician/ gynecologist for routine gynecological care without a referral from their *Primary Care Provider*.

Hearing examinations and screenings.

Any *medically necessary* follow-up care as a result of a routine physical or routine annual gynecological exam is subject to a *cost sharing* amount.

Prevention and Early Detection Services

Your coverage level will be different for preventive screenings (covered in full) versus diagnostic services (subject to member *cost sharing*).

Preventive care services include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.

- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

- With respect to infants, children and adolescents, evidence-informed *preventive care* and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

- With respect to women, such additional *preventive care* and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

For example, coverage is provided for the following preventive screenings:

- Preventive screenings for colon and colorectal cancer. Examples include colonoscopy and sigmoidoscopy screenings.

- Routine Pap smears including coverage for one annual screening for women age 18 and older in accordance with guidelines established by the American Cancer Society.
- Routine mammograms in accordance with guidelines established by the American Cancer Society.
- Two (2) screening mammograms per year are covered when recommended by a physician for women who have been treated for breast cancer within the last 5 years or are at high risk of developing breast cancer due to genetic predisposition (BRCA gene mutation or multiple first degree relatives) or high risk lesion on prior biopsy (lobular carcinoma in situ) or atypical ductal hyperplasia.
- Prostate and colorectal examinations and laboratory tests for cancer for any non-symptomatic *member*, in accordance with the current American cancer society guidelines.

Radiation therapy

Respiratory therapy or pulmonary *rehabilitation* services

Rehabilitation services must be performed by a physician or by a licensed therapy *provider*. Benefits under this Section include *rehabilitation* services provided in a physician's office or on an *outpatient* basis at a hospital or alternate facility.

Short term speech, physical and occupational therapy services

These services are covered when provided to restore function lost or impaired as the result of an accidental injury or illness. They are also covered to include not only the improvement of function but also the halting or slowing the progression of primary and secondary disabilities, maintaining functioning and prevention of further deterioration.

Habilitative health care services that help a person keep, learn or improve skills and functioning for daily living are covered. An example is therapy for a *child* who is not walking or talking at the expected age. These services may include physical an occupational therapy, speech-language therapy and other services for people with disabilities in a variety of *inpatient* and/or *outpatient* settings.

Smoking cessation counseling sessions

Coverage is provided for individual, group, and telephonic smoking cessation counseling services that:

- Are provided in accordance with current guidelines established by the United States Department of Health and Human Services; and
- Meet the requirements of Rhode Island Office of the Health Insurance Commissioner Regulation 14 and in accordance with Rhode Island General Law§27-18-6.
- Coverage is also provided for prescription and over-the-counter smoking cessation agents. For more information, see the Prescription Drug Benefits section of this *Certificate*.

Vision care

Vision care services for members under age 21 and adults

Routine vision examination

- One routine vision examination per *contract year* is covered. This includes:
- New patient exam;
- Established patient exam;
- Routine ophthalmologic exam with refraction for new or established patient.

Instead of a complete exam, we will cover retinoscopy (when applicable) which includes objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Eyeglasses

- One pair of lenses is covered every *contract year* including:
- Single vision lenses;
- Conventional (lined) bifocal lenses;
- Conventional (lined) trifocal lenses; and
- Lenticular lenses

Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, and lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses.

Polycarbonate lenses are covered in full for Children, monocular patients and patients with prescriptions > +/- 6.00 diopters.

All lenses include scratch resistant coating with no additional cost-sharing amount.

Frames are also covered once every *contract year*.

You are eligible to select only one of either eyeglasses (eyeglass lenses and/ or eyeglass frames) or contact lenses. If you select more than one of these vision care services, we will pay benefits for only one vision care service.

Other Vision Services

- Optional Lenses and Treatments:
- Ultraviolet Protective Coating
- Polycarbonate Lenses
- Blended Segment Lenses
- Intermediate Vision Lenses
- Standard Progressives
- Premium Progressives (Varilux®, etc.)
- Photochromic Glass Lenses
- Plastic Photosensitive Lenses (Transitions®)
- Polarized Lenses
- Standard Anti-Reflective (AR) Coating
- Premium AR Coating
- Ultra AR Coating

- Hi-Index Lenses

Contact lenses

Contact Lenses are covered once every *contract year* in lieu of eyeglasses. Additional coverage is provided for the cost of evaluation, materials, fitting and follow-up care.

You are eligible to select only one of either eyeglasses (eyeglass lenses and/ or eyeglass frames) or contact lenses. If you select more than one of these vision care services, we will pay benefits for only one vision care service.

Medically necessary Contact Lenses

Medically necessary and appropriate contact lenses in lieu of eyeglasses are covered. Contact lenses may be determined to be *medically necessary* in the treatment of the following conditions:

- Keratoconus,
- Pathological myopia,
- Aphakia,
- Anisometropia,
- Aniseikonia,
- Aniridia,
- Corneal disorders,
- Post-traumatic disorders, and
- Irregular astigmatism.
- *Medically necessary* contact lenses are dispensed in lieu of other eyewear.

Vision care services for members under age 21

Low Vision

Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and

provide training and instruction to maximize the remaining usable vision for our Members with low vision.

Covered low vision services include:

- One comprehensive low vision evaluation every 5 years, with a maximum charge of $300;
- Maximum low vision aid allowance of $600 with a lifetime maximum of $1,200 for items such as high-power spectacles, magnifiers and telescopes; and
- Follow-up care – four visits in any five-year period, with a maximum charge of $100 each visit.

Inpatient care

Hospital Services

Coverage is provided for unlimited days at general hospital or a specialty hospital and a maximum of 45 days per *contract year* for physical *rehabilitation*. *Covered services* include:

- Anesthesia
- Dialysis
- Intensive care/coronary care
- Physical, occupational, speech, and respiratory therapies
- *Semi-private* room (private room when *medically necessary*)
- Diagnostic tests and lab services
- Drugs
- Nursing care
- Radiation therapy
- Surgery; and
- *Provider*'s services while hospitalized

Reconstructive surgery and procedures and mastectomy surgeries

Coverage is provided for services required to relieve pain or to restore a bodily function impaired as a result of: a congenital defect; birth abnormality; traumatic injury; or covered surgical procedure.

The following services are covered in connection with a mastectomy, in accordance with Rhode Island General Law § 27-18-39:

- Surgical procedures known as a mastectomy;
- Axillary node dissection;

- Reconstruction of the breast affected by the mastectomy,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and treatment of physical complications of all stages of mastectomy (including lymphedema).

Inpatient care in hospital for mastectomies is covered for:

- A minimum of 48 hours following a surgical procedure known as a mastectomy; and
- A minimum of 24 hours following an axillary node dissection.

Any decision to shorten this minimum coverage shall be made by the attending physician in consultation with and upon agreement by the *member*. If the *member* agrees to an early discharge, coverage shall also include a minimum of one home visit conducted by a physician or registered nurse.

Breast prostheses are covered as described under orthoses and prosthetic devices.

Removal of a breast implant is covered when:

- The implant was placed post-mastectomy;
- There is documented rupture of a silicone implant; or
- There is documented evidence of autoimmune disease.

No coverage is provided for the removal of ruptured or intact saline breast implants or intact silicone breast implants except as specified above.

Cosmetic surgery is not covered.

Skilled Care in a Nursing Facility

Care in a *Skilled Nursing Facility* is covered if:

- Your condition needs *skilled* nursing services, *skilled rehabilitation* services or *skilled* nursing observation;
- The services are required on a daily basis; and

- This care can be provided only in a *Skilled Nursing Facility*.

Solid organ and hematopoietic stem cell transplants

Solid organ transplants and hematopoietic stem cell transplants which are generally accepted in the medical community for Members who are the solid organ or stem cell recipients. When the recipient is a *member*, the following services related to the procurement of the stem cells or solid organ from the donor are covered, but only to the extent that such services are not covered by any other plan of health benefits or health care coverage:

- Evaluation and preparation of the donor;
- Surgical intervention and recovery services related directly to donating the stem cells or solid organ to the *member*;
- A *member*'s donor search expenses for donors related by blood;
- The *member*'s donor search expenses for up to 10 searches for donors not related by blood; and
- A *member*'s human leukocyte antigen (HLA) testing.

We do not cover donor *charges* for Members who donate stem cells or solid organs to non-Members.

Maternity care

Maternity care (Outpatient)

Prenatal care, exams, and tests and postpartum care provided in a physician's office are covered.

In accordance with the ACA, laboratory tests associated with routine maternity care are covered in full.

Maternity care (*Inpatient*)

Hospital and delivery services and newborn in hospital child care are covered.

Coverage includes the services of licensed midwives for services within the licensed midwives' area of professional competence as defined by Rhode Island regulations Section

§23-13-9 and are currently reimbursed when rendered by any other licensed health care *provider*. Payment for licensed midwives will be made for services provided in a licensed health care facility and in accordance with department of health rules and regulations.

Coverage includes *inpatient* care in hospital for mother and newborn *child* for at least 48 hours following a vaginal delivery and 96 hours following a caesarean delivery.

The attending health care *provider* will make any decision to shorten the minimum coverage. In addition, this decision must be in consultation with the mother. The decision must be in accordance with the standards for guidelines for perinatal care published by the American College of Obstetrics and Gynecology and the American Academy of Pediatrics.

In the case of early discharge, covered post-delivery care will include home visits, parent education, assistance and training in breast or bottle-feeding and the performance of any necessary and appropriate clinical tests or any other tests or services consistent with the guidelines in this subsection.

The newborn *child*'s coverage consists of coverage of injury or sickness. This coverage includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, as well as routine well-baby care services.

Coverage of the new-born *child* will continue for 31 days after birth. For coverage to continue beyond this 31-day period, you must enroll the *child*.

Behavioral Health Services for Mental Health Care

Neighborhood provides mental health and substance abuse treatment *covered services* in parity with all other *covered services*. This means that there are no *benefit limits* on mental health and substance abuse treatment services and that these services have no different *cost sharing* than any other *covered service.*

Outpatient mental health care services

Services to diagnose and treat mental disorders in an *outpatient* setting are covered including:

- Individual, group and family therapies;
- Intensive *outpatient* programs;
- Enhanced Outpatient Services; and

- Medication management.

Medically necessary services meeting standard medical management protocols and within the benefit limits are covered. This coverage includes the services of counselors licensed in mental health and therapists licensed in marriage and family practice, excluding marital and family therapy unless the individual is diagnosed with a mental disorder.

Psychopharmacological services and neuropsychological assessment services are covered as *outpatient* medical care.

Inpatient and intermediate mental health care services

Inpatient mental health services for mental disorders in a general hospital, a mental health hospital, or a *chemical dependency* facility are covered.

Intermediate mental health care services are covered. These services are more intensive than traditional community-based *outpatient* mental health care services. They are less intensive than 24-hour hospitalization. Some examples of covered intermediate mental health care services are:

- Acute/Crisis stabilization unit;
- Partial hospital programs;
- Day/Evening Treatment; and
- Acute residential treatment (longer term residential treatment is not covered).); and adult intensive services (AIS).

AIS is a facility-based mental health care program. Adult intensive services are primarily based in the home for qualifying adults with moderate to severe psychiatric conditions. This program must consist of, but is not limited to, the following:

- Ongoing emergency or crisis evaluations 24 hours a day 7 days per week;
- Psychiatric assessment;
- Medication evaluation and management;
- Case management;
- Psychiatric nursing services; and

- Individual, group, and family therapy.

Under this AIS program, a *provider* must provide a minimum of six contact hours per week.

No visit limit applies to *inpatient* or intermediate mental health care services.

Behavioral Health Services for Chemical Dependency

Neighborhood provides mental health and substance abuse treatment *covered services* in parity with all other *covered services*. This means that there are no *benefit limits* on mental health and substance abuse treatment services and that these services have no different *cost sharing* than any other *covered service.*

Outpatient chemical dependency services

Outpatient chemical dependency treatment services are covered. Methadone maintenance or methadone treatment related to chemical dependency disorders are covered.

Treatment for the abuse of tobacco or caffeine is not covered under these *chemical dependency* services benefits.

Inpatient and Intermediate chemical dependency services

Inpatient detoxification and treatment services in a general hospital, *chemical dependency* facility, or community residence is covered.

Intermediate *chemical dependency* services are more intensive than traditional community-based *outpatient chemical dependency* services. They are less intensive than 24-hour hospitalization. Some examples of covered intermediate *chemical dependency* services are:

- Partial hospital programs;
- Day/Evening treatment;
- Intensive Outpatient program; and
- Enhanced Outpatient program, intensive *outpatient* programs.

Intermediate *chemical dependency* services include adult intensive services (AIS).

AIS is a facility-based *chemical dependency* program. Adult intensive services are primarily based in the home for qualifying adults with moderate to severe *chemical dependency* conditions. This program must consist of, but is not limited to, the following:

- Ongoing *emergency* or crisis evaluations available 24 hours a day 7 days per week;
- Psychiatric and addiction assessment;
- Medication evaluation and management;
- Case management;
- Addiction nursing services; and
- Individual, group, and family therapy.

Under this AIS program, a *provider* must provide a minimum of six contact hours per week.

Other health services

Ambulance services

Ground, sea, and air ambulance transportation for *emergency* care is covered. If you refuse to be transported to the hospital or other medical facility you will be responsible for the costs of this treatment.

Non-emergency ambulance transportation for *medically necessary* care is covered when the member's medical condition prevents safe transportation by any other means.

Clinical trials

Coverage is provided for individuals participating in approved clinical trials.

- An approved clinical trial means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or a life-threatening disease or condition and is described in any of the following:
- The study or investigation is approved or funded, which may include funding through in-kind contributions, by one or more of the following:
    - The federal National Institutes of Health;

- The federal Centers for Disease Control and Prevention;
- The federal Agency for Health Care Research and Quality;
- The federal Centers for Medicare & Medicaid Services;
- A cooperative group or center of any of the entities described above or the U.S. Department of Defense or the U.S. Department of Veterans' Affairs;
- A qualified non-governmental research entity identified in the guidelines issued by the federal National Institutes of Health for center support grants; or
- A study or investigation conducted by the U.S. Department of Veterans' Affairs, the U.S. Department of Defense, or the U.S. Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of U.S. Department of Health and Human Services determines:
  - Is comparable to the system of peer review of studies and investigations used by the Federal National Institutes of Health; and
  - Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration; or
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Neighborhood will not:

- Deny a qualified *member* participation in an approved clinical trial;
- Deny or limit or impose additional conditions on the coverage of items and services furnished in connection with participation in the approved clinical trial; and
- Discriminate against the *member* on the basis of the *member*'s participation in the approved clinical trial.

Durable Medical Equipment

Equipment must meet the following definition of "*Durable Medical Equipment.*"

Durable Medical Equipment is a device or instrument of a durable nature that:

- Is reasonable and necessary to sustain a minimum threshold of independent daily living;
- Is made primarily to serve a medical purpose;
- Is not useful in the absence of illness or injury;
- Can withstand repeated use;
- Can be used in the home.

In order to be eligible for coverage, the equipment must also be the most appropriate available supply or level of service for the *member* in question considering potential benefits and harms to that individual. Neighborhood determines this.

Neighborhood may decide that equipment is: (1) non-medical in nature; and (2) used primarily for non-medical purposes. This may occur even though that equipment has some limited medical use. In this case, the equipment will not be considered *Durable Medical Equipment* and will not be covered under this benefit.

Hearing aids

Coverage is $1,500 per individual hearing aid, per ear, every three (3) years for anyone under the age of 19 years, and $700 per individual hearing aid per ear, every three (3) years for anyone of the age of 19 years and older, in accordance with Rhode Island General Law § 27-41-63.

Home health care

Covered home health care is a *medically necessary* program to reduce the length of a hospital stay or to delay or eliminate an otherwise *medically necessary* hospital admission. Coverage includes:

- Home visits by a physician;
- *Skilled* nursing care and physical therapy;
- Speech therapy;
- Occupational therapy;

- Medical/ psychiatric social work;
- Nutritional consultation;
- Prescription drugs and medication;
- Medical and surgical supplies (Examples include dressings, bandages and casts.);
- Laboratory tests, x-rays, and E.K.G. and E.E.G. evaluations;
- The use of *Durable Medical Equipment*, and
- The services of a part-time *home health aide*.

Hospice care services

We will cover the following services for Members who are terminally ill. Terminally ill means having a life expectancy of 6 months or less:

- Physician services;
- Nursing care provided by or supervised by a registered professional nurse;
- Social work services;
- Volunteer services; and
- Counseling services (This includes bereavement counseling services for the *member*'s family for up to one year after the *member*'s death).

Hospice services can be provided in a home setting, on an *outpatient* basis; and on a short-term *inpatient* basis, for the control of pain and management of acute and severe clinical problems which cannot, for medical reasons, be managed in a home setting.

Injectable, infused or inhaled medications

Coverage is provided for injectable, infused or inhaled medications that are:

- Required for and an essential part of an office visit to diagnose and treat illness or injury; or
- Received at home with drug administration services by a home infusion *provider*.

Medications may include, but are not limited to, total parenteral nutrition therapy, chemotherapy, and antibiotics. Coverage includes the components required to administer these medications. This includes, but is not limited to, *Durable Medical Equipment*, supplies, pharmacy compounding, and delivery of drugs and supplies.

There are designated home infusion *provider*s for a select number of specialized pharmacy products and drug administration services. These *provider*s offer clinical management of drug therapies, nursing support, and care coordination to Members with acute and chronic conditions. Medications offered by these *provider*s include, but are not limited to, medications used in the treatment of hemophilia, pulmonary arterial hypertension, immune deficiency, and enzyme replacement therapy.

Medications listed on our web site as covered under a Neighborhood pharmacy benefit are not covered under this "Injectable, infused, or inhaled medications" benefit.

Medical supplies

We cover the cost of certain types of medical supplies including ostomy, tracheostomy, catheter, and oxygen supplies; and insulin pumps and related supplies.

New Cancer Therapies for cancer or other life-threatening diseases or conditions

Coverage is provided for both *inpatient* and *outpatient* new cancer therapies still under investigation as required by Rhode Island General Laws Section § 27-18-36.

To the extent required by Rhode Island and federal law, new therapies provided as part of an approved clinical trial conducted to prevent, detect, or treat cancer or other life-threatening diseases or conditions are covered to the same extent as those services would be covered if the *member* did not receive care in an approved clinical trial.

Orthoses and prosthetic devices

We cover the cost of orthoses and prosthetic devices, including repairs, as required by Rhode Island law. This includes breast prostheses as required by federal law.

Coverage is provided for the most appropriate model that adequately meets the *member*'s needs. His or her treating *provider* determines this.

The scalp hair prosthesis or wig benefit is limited to the *maximum benefit* of $350 per member per *contract year* when worn for hair loss suffered as a result of cancer treatment in accordance with Rhode Island General Law 26-18-68.

Special medical formulas

Coverage includes low protein foods when given to treat inherited diseases of amino acids and organic acids.

Nonprescription enteral formulas are covered for home use 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.

A *provider* must prescribe the formula or food for these treatments. Coverage shall not exceed an amount of two thousand five hundred dollars ($2,500) per covered member per year.

SECTION 3 Prescription drug benefits

Section 3.1 Your prescription drug benefits

Introduction

This section describes the prescription drug benefit. These topics are included here. They explain your prescription drug coverage:

- How Prescription Drugs Are Covered;
- Prescription Drug Coverage Table;
- Management; Programs;
- What is Covered;
- What is Not Covered;
- *Neighborhood* Pharmacy
- Filling Your Prescription.

How Prescription Drugs Are Covered

Neighborhood offers a complete list of covered drugs. This list of covered drugs is called our Formulary. See our website at www.nhpri.org. for a list of covered drugs on our Formulary. You can also call a Member Specialist. In addition , Drugs listed on our Formulary are covered only if they comply with the "Neighborhood Health Plan of Rhode Island (Neighborhood) Pharmacy Management Programs" section below and are:

- provided to treat an injury, illness, or pregnancy and

- *Medically Necessary*

The "Prescription Drug Coverage Table" below describes your prescription drug benefit amounts.

- Tier-1 Generic Drugs have the lowest] level *Cost Sharing Amount*; many generic drugs are on Tier-1.
- Tier-2 Preferred Brand Drugs have the middle] a higher] level *Cost Sharing Amount*.
- Tier-3 Non Preferred Brand Drugs have the higher] highest] level *Cost Sharing Amount*.]

ALL OTHER MEDICATIONS OBTAINED AT A RETAIL PHARMACY:
Covered prescription drugs include both acute and maintenance drugs. Prescription drugs covered up to a 30-day supply. You need to obtain these drugs directly from a Neighborhood designated retail pharmacy.

Tier-1 drugs:	**Tier-2 drugs:**	**Tier-3 drugs:**
$2-$10 Copayment	$4-$40 Copayment	$6-$60 Copayment
for a 1-30-day supply	for a 1-30-day supply	for a 1-30-day supply

- You always pay the applicable Cost Sharing Amount. This is the case even if the cost of the drug is less than the Cost Sharing Amount.
- Generic Incentive Program: Your Provider may prescribe a brand-name drug that has a generic equivalent. This can happen in Rhode Island and many other states. In this case, you will receive the generic drug and pay the applicable Tier Cost Sharing Amount.
- Wherever you fill your prescription, your Provider may request that you receive a covered brand-name drug only. In this case, you will pay the Cost Sharing Amount for the generic drug.
- You will also need to pay the difference between the cost of the generic drug and the cost of the covered brand-name drug. In many cases, there may be a significant difference in what you need to pay.

<u>Additional Coverage information related to drugs that are included on our Formulary</u>

We cover the following under this Prescription Drug Benefit when the drug or device is listed on our Formulary:

- Test strips for glucose monitors, insulin, insulin syringes, and oral agents for controlling blood sugar levels

- Specific Oral contraceptives, diaphragms, and other hormonal contraceptives (e.g., patches, rings) that by law require a prescription*

  *Note: This Prescription Drug Benefit only describes contraceptive coverage for oral contraceptives, diaphragms, and other hormonal contraceptives (e.g., patches, rings) that by law require a prescription. See "Family planning" above for information about other covered contraceptive drugs and devices.

- Fluoride for Children'

- Specific Injectables and biological serum Off-label use of FDA-approved prescription drugs used in the treatment of cancer which have not been approved by the FDA for that indication, provided, however, that such a drug is recognized for such treatment in one of the standard reference compendia, in the medical literature, or by the commissioner of insurance.

- Compounded medications are only covered if at least one active ingredient requires a prescription by law;

- Specific over-the-counter drugs at **www.nhpri.org**.

- Specific prescription and over-the-counter smoking cessation agents that are recommended and prescribed by a Neighborhood Plan *provider*'; this benefit is subject to prior authorization.

Certain prescription drug products may be subject to a Neighborhood Pharmacy Management Program described below.

Section 3.2 Pharmacy management programs

In order to provide safe, clinically appropriate, cost-effective medications under this Prescription Drug Benefit, we have developed the following Pharmacy Management Programs.

Quantity Limitations Program

We limit the quantity of selected medications Members can receive in a given time period. We do this for cost, safety, and/or clinical reasons.

Prior Authorization Program

We restrict the coverage of certain drug products. These are drugs with a narrow indication for usage, may have safety concerns, and/or are extremely expensive. We require the prescribing *provider* to obtain prior approval from us for such drugs.

Step therapy is a type of prior authorization program. This program uses a step-wise approach. It requires the use of the most therapeutically appropriate and cost-effective agents first. After that, other medications may be covered. You must try one or more medications on a lower step to treat a certain medical condition first. After that, we may cover a medication on a higher step for that condition.

Non-Covered Drugs:

A small number of drugs are not covered. Typical drugs not covered include

- Drugs and/or drug therapies for cosmetic purposes including but not limited to treatment of facial wrinkles; "fungal" nails not confirmed by laboratory results; hair restoration (except as an adjunct to chemotherapy; hair removal; vitiligo.
- Drugs and/or drug therapies used for the treatment of erectile dysfunction
- Experimental drugs and/or drug therapies
- Drugs and/or drug therapies used for the treatment of infertility
- Drugs used to terminate pregnancies.

New-To-Market Drug Evaluation Process

Neighborhood Pharmacy and Therapeutics Committee reviews new-to-market drug products for safety, clinical effectiveness and cost. The review is generally completed within the 6 month period following the marketing launch of the drug. We then make a coverage determination based on the Pharmacy and Therapeutics Committee's recommendation.

Drugs that have not yet been reviewed and approved by the Neighborhood Pharmacy and Therapeutics Committee are subject to our prior authorization policy and may not be covered.

Important Notes:

- Your *provider* may feel it is *medically necessary* for you to take medications that are not on the formulary or restricted under any of the "Neighborhood Pharmacy Management Programs" above. In this case, he or she may submit a request for coverage. We will approve the request if it meets our guidelines for coverage. For more information, call a *Member Services* representative.

- You may have questions about your prescription drug benefit. You may want to know the tier of a particular drug. You might like to know if your medication is part of a Pharmacy Management Program. For these issues, check our Web site at www.nhpri.org. You can also call a *Member Services* representative at 855-321-XCHG (855-321-9244)

- Where to Fill Prescriptions:

Fill your prescriptions at a Neighborhood designated pharmacy. Neighborhood designated pharmacies include:

- For the majority of prescriptions, most of the pharmacies in Rhode Island. They also include additional pharmacies nationwide.

How to Fill Prescriptions:

- When you fill a prescription, provide your Member ID to any Neighborhood designated pharmacy, and pay your *cost sharing* amount.

- The cost of your prescription may be less than your Copayment. In this case, you only need to pay the actual cost of the prescription.

- If you have any problems using this benefit at a Neighborhood designated pharmacy, call the *Member Services* Department.

Important: Only at Neighborhood designated pharmacies will honor your prescription drug benefit. In cases where you obtained drugs from a pharmacy other than a Neighborhood pharmacy due to an *emergency*, call *Member Services*. They can explain how to submit your prescription drug *claim*s for reimbursement.

SECTION 4 Benefits not covered by the plan

Section 4.1 Benefits we do not cover (exclusions)

This section tells you what kinds of benefits are "excluded." The term "excluded" means that the plan does not cover these benefits.

The list below describes some services and items that are not covered under any conditions and some that are excluded only under specific conditions.

If you get benefits that are excluded, you must pay for them yourself. We will not pay for the excluded benefits listed in this section (or elsewhere in this *Certificate*). The only exception:

If a benefit on the exclusion list is found upon *appeal* to be a benefit that we should have paid for or covered because of your specific situation.

Not *Medically necessary*.

A service, supply or drug that is not *medically necessary*. *Medically necessary* health care services are those services, supplies or medications provided for the purpose of preventing, evaluating, diagnosing or treating an injury, illness, or pregnancy, and which are all of the following.

- In accordance with generally accepted standards of medical practice. Generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your injury, illness, or pregnancy.
- Not more costly than an alternative, service, supply or medication that is at least as likely to produce equal results as to the diagnosis or treatment of your injury, illness, or pregnancy.
- Not primarily for your, or another person's personal comfort or convenience.

Coverage for *Medically necessary preventive care* is governed by terms of this *Certificate*.

Not a Covered Service.

Health services and supplies that do not meet the definition of a Covered Service which are services, supplies, or medications which we determine are all of the following:

- *Medically necessary*.
- Described as a Covered Service in this *Certificate*.
- Not otherwise excluded in this *Certificate*.

Facility *charges* or related services if the procedure being performed is not a Covered Service, except as provided elsewhere in this *Certificate*.

Services provided outside the United States.

Any service, supply, or medication that is obtained outside of the 50 United States is not covered. The only exceptions to this rule are for *emergency* care services or urgent care services while traveling.

Custodial Care

Custodial care, rest care, day care, or non-*skilled* care in any facility is not covered, including care in convalescent homes, nursing homes, homes for the aged, halfway houses, or other residential facilities. *Custodial care* services include, but are not limited to:

- Any homemaking, companion, or chronic (custodial) care services;
- The services of a personal care attendant;
- *Charges* for private duty nursing when primary duties are limited to bathing, feeding, exercising, homemaking, giving oral prescription drugs or acting as a companion.

A service, supply, or medication that is experimental or investigational

We will not pay for any related treatments provided to the *member* for the purpose of furnishing the *experimental* or *investigative* treatment. The fact that an *experimental* or investigational service, supply or drug is the only available treatment for a particular condition will not result in benefits for that condition. This exclusion does not apply to services which meet coverage requirements under Rhode Island and federal law for:

- Treatment of chronic Lyme disease;
- New therapies conducted to prevent, detect, or treat cancer or other life-threatening diseases or conditions; or
- Off-label uses of prescription drugs for the treatment of cancer.

Services provided by the relatives of a *member*

Services provided by a relative who is not a *provider* are not covered. If the relative is a *provider*, services provided by an immediate family member (by blood or marriage) are not covered.

If you are a *provider*, you cannot provide or authorize services for yourself or a member of your immediate family (by blood or marriage).

Services covered by other entities or services that would otherwise not be covered

The following services, supplies, or drugs are not covered:

- Services, supplies, or medications required by a third party which are not otherwise *medically necessary*. Examples of a third party are an employer, an insurance company, a school, or a court.
- Services for which you are not legally obligated to pay. Services for which no charge would be made if you had no health plan.
- Care for conditions for which benefits are covered under Federal, State or Local legislation such as workers' compensation or no fault auto insurance, or other government programs other than Medicaid.
- Care for conditions that state or local law requires to be treated in a public facility.
- Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
- Health services while on active military duty.
- Any additional fee a *provider* may charge as a condition of access or any amenities that access fee is represented to cover.

Personal Care, Comfort or Convenience Items

Charges incurred when the *member*, for his or her convenience, chooses to remain an *inpatient* beyond the discharge hour.

Supplies, equipment and similar services and supplies primarily for personal comfort are not covered.

Incidental services such as television, telephone and beauty/ barber service or guest service are not covered.

Dental Care Services

The following dental care services, treatments, and supplies are excluded:

- Preventive dental care not described in this *Certificate* as covered;

- Dental supplies;
- Dentures;
- Skeletal jaw surgery, except as provided under "Oral health services" earlier in this *Certificate*;
- Alteration of teeth;
- Care related to deciduous (baby) teeth;
- Splints and oral appliances (except those described in this *Certificate* as covered), including those for temporomandibular joint (TMJ) disorders. TMJ disorder- related therapies, including TMJ appliances, occlusal adjustment, or TMJ appliance-related therapies, are not covered.

Cosmetic Services

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

Except *covered services* described in this *Certificate*, services, supplies or medications to change or improve appearance are not covered. This includes, but is not limited to:

- Excision of excess skin or subcutaneous tissue including brachioplasty (arm lift) or abdominoplasty (tummy tuck) (except Panniculectomy as described in this *Certificate*);
- Cervicoplasty (Plastic surgery on the neck or on the cervix of the uterus);
- Laser treatment for acne and acne scars;
- Chemical exfoliations, peels, abrasions (or dermabrasions or planing for acne, scarring, wrinkling, sun damage or other conditions);
- Correction of variations in normal anatomy including augmentation mammoplasty, mastopexy, and correction of congenital breast asymmetry (modifying the size, contour, and elevation of breasts);
- Gynecomastia surgery, including but not limited to mastectomy and reduction mammoplasty;

- Genioplasty (reduction and addition of material to the chin);
- Hair transplants;
- Hair removal (including electrolysis epilation);
- Inverted nipple surgery;
- Osteoplasty (facial bone reduction);
- Otoplasty (ear plastic surgery);
- Repeated cauterizations or electrofulguration methods used to remove growths on the skin;
- Rhinoplasty (nose plastic surgery);
- Rhytidectomy (facelift);
- Scar Revision, regardless of symptoms;
- Sclerotherapy/ treatment for spider veins;
- Subcutaneous injection of filling material;
- Liposuction/ suction assisted lipectomy (remove fatty deposits in the thighs, neck, arms, and stomach);
- Tattooing or Tattoo Removal (except tattooing of the nipple/areola related to a mastectomy);
- Testicular prosthesis surgery;
- Removal or destruction of skin tags;
- Treatment of vitiligo (white patches on your skin);
- Scalp hair prostheses made specifically for an individual, or a wig, and provided for hair loss due to alopecia areata, alopecia totalis, or permanent loss of scalp hair due to injury.

Medications and other products which can be purchased over-the- counter except those listed as covered and listed on our Formulary on our website at www.nhpri.org.

Laboratory tests ordered by a *member* are not covered even if they are performed at a licensed laboratory.

Pregnancy terminations.

Costs associated with home births; costs associated with the services provided by a doula.

Circumcision performed in any setting other than a hospital, Day Surgery, or a physician's office.

Infertility services

Infertility treatment is not covered for:

- Members who do not meet the definition of Infertility;
- *Experimental* infertility procedures;
- The costs of surrogacy*;
- Long-term (longer than 90 days) sperm or embryo cryopreservation unless the *member* is in active infertility treatment;
- Costs associated with donor recruitment and compensation;
- Infertility services which are necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization; and
- Donor sperm and associated laboratory services in the absence of diagnosed male factor infertility in the partner.
- Drugs for anonymous or designated egg donors that are directly related to a stimulated Assisted Reproductive Technology (ART) cycle, unless the *member* is the sole recipient of the donor's eggs. Prior authorization is recommended for these services.

*the costs of surrogacy means:

- (1) All costs incurred by a fertile woman to achieve a pregnancy as a surrogate or gestational carrier for an infertile *member*. These costs include, but are not limited to: costs for drugs needed for implantation, embryo transfer, and cryopreservation of embryos;
- (2) Use of donor egg and a gestational carrier; and
- (3) Costs for maternity care if the surrogate is not a *member*.
- A surrogate is a person who carries and delivers a *child* for another either through artificial insemination or surgical implantation of an embryo.
- A gestational carrier is a surrogate with no biological connection to the embryo/*child*.

- Note: We may authorize short-term (less than 90 days) cryopreservation of sperm or embryos for certain medical conditions that may impact a *member*'s future fertility. Prior authorization is recommended for these services.

Treatments, medications, procedures, services and supplies related to: medical or surgical procedures for sexual reassignment; reversal of voluntary sterilization; or over-the-counter contraceptive agents.

Human organ transplants, except as described in this Certificate as covered.

The purchase of an electric hospital grade breast pump

Services provided to a non-*member*, except as described in this Certificate for:

- Organ donor *charges* under "Human organ transplants";
- Bereavement counseling services under "Hospice care services"; and
- The costs of procurement and processing of donor sperm, eggs, or inseminated eggs, or banking of donor sperm or inseminated eggs, under "Infertilityservices." (This is to the extent such costs are not covered by the donor's health coverage, if any.)

Alternative, holistic, naturopathic, and/or functional health medicine services

- All alternative, holistic, naturopathic, and/or functional health medicine services, supplies or procedures are not covered.

- All services, procedures, labs and supplements associated with this type of medicine are not covered.

Services, programs, supplies, or procedures performed in a non-conventional setting

This includes, but is not limited to, spas/resorts, educational, vocational, or recreational settings, Outward Bound, or wilderness, camp or ranch programs.

This is the case even if the services, programs, supplies or procedures are performed or provided by licensed *provider*s, such as mental health professionals, nutritionists, nurses or physicians. Some examples of services that may be excluded if they are performed in a non-conventional setting are psychotherapy, ABA services, and nutritional counseling.

Blood and Blood Related Services

Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking and blood products, except as below.

Note: The following blood services and products are covered:

- Blood processing;
- Blood administration;
- Factor products (monoclonal and recombinant) for Factor VIII deficiency (classic hemophilia), Factor IX deficiency (Christmas factor deficiency), and von Willebrand disease (prior authorization is recommended for these services);
- Intravenous immunoglobulin for treatment of severe immune disorders, certain neurological conditions, infectious conditions, and bleeding disorders (prior authorization is recommended for these services).

Devices and procedures intended to reduce snoring.

Exclusions include, but are not limited to, laser- assisted uvulopalatoplasty, somnoplasty, and snore guards.

Examinations, evaluations or services for educational or developmental purposes

Exclusions include:

- Physical therapy, speech therapy, and occupational therapy, except those described as covered in this *Certificate*.

- Vocational *rehabilitation* services and vocational retraining.

- Services to treat learning disabilities, behavioral problems, and developmental delays and services to treat speech, hearing and language disorders in a school-based setting.

The term "developmental" refers to a delay in the expected achievement of age-appropriate fine motor, gross motor, social, or language milestones not caused by an underlying medical illness or condition.

Eyeglasses, lenses, or frames

Except as described in this *Certificate* as covered, exclusions include refractive eye surgery (including radial keratotomy) for conditions that can be corrected by means other than surgery, contact lenses, or contact lens fittings.

Prescription Drug Benefit:

- Prescription and over-the-counter homeopathic medications.

- Over the counter drugs that by law do not require a prescription except those that are included on our Formulary

- Drugs not listed on the "Neighborhood Formulary". See the list at **www.nhpri.org**. Also, you can call *Member Services* for more information.

- Vitamins and dietary supplements (except prescription prenatal vitamins and fluoride for Children and supplements for the treatment of mitochondrial disease that are included on our Formualry]).

- Topical and oral fluorides for adults.

- Cervical caps, IUDs, implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants), Depo-Provera or its generic equivalent. Although not covered under the prescription drug benefit, these are covered under your *outpatient* care benefit earlier in this chapter. Oral contraceptives, diaphragms and other hormonal contraceptives (e.g., patches, rings) that by law require a prescription are covered under the prescription benefit.

- *Experimental* drugs: drugs that cannot be marketed lawfully without the approval of the FDA and such approval has not been granted at the time of their use or proposed use or such approval has been withdrawn.
- Non-drug products such as therapeutic or other prosthetic devices, appliances, supports, or other non-medical products. These may be provided as described earlier in this chapter.
- Prescriptions filled at pharmacies other than Neighborhood designated pharmacies, except for *emergency* care.
- Drugs dispensed in an amount or dosage that exceeds our established quantity limitations.
- Compounded medications, if no active ingredients require a prescription by law.
- Prescription medications once the same active ingredient or a modified version of an active ingredient that is therapeutically equivalent to a covered prescription medications becomes available over-the-counter. In this case, the specific medication may not be covered. Also, the entire class of prescription medications may also not be covered. For more information, call *Member Services*. You can also check our Web site at **www.nhpri.org**.
- Prescription medications when packaged with non-prescription products.
- Drugs for the treatment of erectile dysfunction.

Pediatric vision care services, treatments and supplies

Pediatric vision care services exclude:

- Services and materials not meeting accepted standards of optometric practice.
- Special lens designs or coatings other than those described as *covered services*.
- Replacement of lost or stolen eyewear.
- Non-prescription (Plano) lenses.
- Two pairs of eyeglasses in lieu of bifocals.
- Insurance of contact lenses.

Routine foot care

Routine foot care is not a covered service including the treatment of corns, calluses, the trimming of nails, cutting, or debriding, treatment of flat feet or subluxation of the foot; the treatment of simple ingrown nails and other preventive hygienic procedures, orthopedic shoes and related items that are not part of a brace; or other support devices for the feet.

Note: This exclusion does not apply to routine foot care for Members diagnosed with diabetes.

Transportation

Exclusions include, but are not limited to transportation by chair car, wheelchair van, or taxi, except as described in "Ambulance services" in this *Certificate*.

Lodging

Lodging is not covered even when related to receiving any medical service.

Devices, Appliances and Prosthetics138

Non-covered services include, but are not limited to:

- Devices used specifically as safety items or to affect performance in sports-related activities.
- Orthotic appliances that straighten or re-shape a body part such as foot orthotics and cranial banding.
- Some types of braces, including over-the-counter orthotic braces.

Other Services

- Acupuncture; biofeedback, except for the treatment of urinary incontinence;
- Hypnotherapy;
- Psychoanalysis;
- TENS units or other neuromuscular stimulators and related supplies;
- Electrolysis;

- Spinal manipulation;
- *Inpatient* and *outpatient* weight-loss programs and clinics;
- Nutritional counseling, except as described in this *Certificate*;
- Relaxation therapies; massage therapies, except as described under "Short-term speech, physical, and occupational therapy services" in this *Certificate*;
- Services by a personal trainer;
- Exercise classes;
- Cognitive *rehabilitation* programs;
- Cognitive retraining programs.
- Also excluded are diagnostic services related to any of these procedures or programs.

Pediatric Dental Services

- Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible *covered services* provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;
- Those which are for specialized procedures and techniques;
- Those performed by a dentist who is compensated by a facility for similar *covered services* performed for Members;
- Duplicate, provisional and temporary devices, appliances and services;
- Plaque control programs, oral hygiene instruction and dietary instructions;
- Services to alter vertical dimension and/ or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth *rehabilitation* and restoration for misalignment of teeth;
- Gold foil restorations;

- *Charges* by the *provider* for completing dental forms;
- Adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;
- Use of material or *home health aide*s to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
- Sealants for teeth other than permanent molars;
- Precision attachments, personalization, precious metal bases and other specialized techniques;
- Replacement of dentures that have been lost, stolen or misplaced;
- Repair of damaged orthodontic appliances;
- Replacement of lost or missing appliances;
- Fabrication of athletic mouth guard;
- Internal bleaching;
- Nitrous oxide;
- Oral sedation;
- Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection.

Non-Medical Services

- Any *charges* for failure to keep a scheduled appointment;
- Services or treatment provided as a result of intentionally self-inflicted injury or illness;
- Office infection control charges;
- *Charges* for copies of your records, charts or X-rays, or any costs associated with forwarding/mailing copies of your records, charts or X-rays;
- State or territorial taxes on services performed;

The plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.

Chapter 5. Asking us to pay our share of a bill you received for covered medical services

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services

Section 1.1 If you pay our plan's share of the cost of your covered services, or if you receive a bill, you can ask us for payment

We pay *network provider*s directly for *covered services*. However, occasionally, you may receive a bill from a *provider* for *covered services*

Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services that are covered by our plan.

There may also be times when you get a bill from a *provider* for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the *provider* directly.

Our payments to you or the *provider* fulfill our responsibility under this agreement. Your benefits are personal to you and cannot be assigned, in whole or in part, to another person or organization. We reserve the right to be reimbursed by the Member for payments made due to our error.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

1. When you've received *emergency* or urgently needed medical care from a *provider* who is not in our plan's network

   You can receive *emergency* services from any *provider*, whether or not the *provider* is a part of our network. When you receive *emergency* or urgently needed care from a *provider* who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the *provider* to bill the plan for our share of the cost.

   - If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.

- At times you may get a bill from the *provider* asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
    - If the *provider* is owed anything, we will pay the *provider* directly.
    - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

2. When a *network provider* sends you a bill you think you should not pay

Network *provider*s should always bill the plan directly, and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share.

- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow *provider*s to add additional separate charges, called "*balance billing*." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the *provider* less than the *provider charges* for a service and even if there is a dispute and we don't pay certain *provider* charges.
- Whenever you get a bill from a *network provider* that you think is more than you should pay, send us the bill. We will contact the *provider* directly and resolve the billing problem.
- If you have already paid a bill to a *network provider*, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. When you obtain a prescription at a non-designated pharmacy

- If you need to obtain a prescription at a non-designated pharmacy, you will need to pay for the prescription up front and submit a claim for reimbursement.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can *appeal* our decision. Chapter 7 of this booklet (What to do if you have a problem or complaint (coverage decisions, *appeal*s, *complaint*s) has information about how to make an *appeal*.

SECTION 2 How to ask us to pay you back or to pay a bill you have received

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

Send us an itemized bill along with the following:

- *Subscriber*'s name and address;
- Your member identification number;
- Patient's name and age;
- 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 statement that indicates either that you are or you are not enrolled for coverage under any other health insurance plan and program. If you are enrolled for other coverage, you must include the name of the other carrier(s).

Mail your request for payment together with any bills or receipts to us at this address:

Member Services
Neighborhood Health Plan of Rhode Island
299 Promenade Street
Providence, Rhode Island 02908

Note: You must contact us regarding your bill(s) or send your bill(s) to us within 90 days from the date of the covered service, or as soon as reasonably possible. If you do not, the bill cannot be considered for payment, unless you are legally incapacitated. In no event, except in cases of legal incapacitation, can bills be considered for payment after a period of 1 year.

If you receive *covered services* from a non-Neighborhood Plan *provider*, we will pay up to the Reasonable Charge for the services within 60 days of receiving a completed Member Reimbursement Medical *Claim* Form and all required supporting documents.;

Contact *Member Services* if you have any questions. If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the service and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care is covered and you followed all the rules for getting the care, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the *provider*. (Chapter 3 explains the rules you need to follow for getting your medical services covered.)

- If we decide that the medical care is not covered, or you did not follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to *appeal* that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an *appeal*. If you make an *appeal*, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this *appeal*, go to Chapter 7 of this booklet (What to do if you have a problem or complaint (coverage decisions, *appeal*s, *complaint*s). The *appeal*s process is a formal process with detailed procedures and important deadlines.

Chapter 6. Your rights and responsibilities

SECTION 1 Our plan must honor your rights as a member of the plan

Section 1.1 Your Rights as a member

We support your rights as a member of Neighborhood and want to work with you to be sure that you receive the highest quality health care and services that you deserve. Please read your rights and responsibilities as a member of Neighborhood carefully:

- You have the right to receive information about Neighborhood, its services, *provider*s and *provider*s, and Members' rights and responsibilities.
- You have the right to be treated with respect and recognition of your dignity and right to privacy.
- You have the right to participate with your practitioners in decision-making regarding your health care.
- You have the right to privacy of all records and communications to the extent required by law. (Neighborhood employees follow a strict confidentiality policy regarding all member information.)
- You have the right to respectful, personal attention without regard to your race, national origin, gender, age, sexual orientation, religious affiliation, or preexisting conditions.
- You have the right to obtain a second medical opinion for medical and surgical concerns.
- You have the right to a candid discussion of appropriate or *medically necessary* treatment options for your conditions, regardless of cost or benefit coverage.
- You have the right to voice complaints or *appeal*s about Neighborhood or the care provided by its *provider*s.
- You have the right to make recommendations about Neighborhood's Member Rights and Responsibilities policies.

To get information from us in a way that works for you, please call *Member Services*.

Our plan has people and free language interpreter services available to answer questions from non-English speaking Members. We can also give you information in Braille, in large print, or other alternate formats if you need it.

Section 1.2 You have the right to receive information about Neighborhood, its services, network of providers, and Members' Rights and Responsibilities

As a member of Neighborhood Exchange Health Plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call *Member Services*.

- Information about our *network provider*s.
    - You have the right to get information from us about the qualifications of the *provider*s in our network and how we pay the *provider*s in our network.
    - For a list of the *provider*s in the plan's network, see the *Provider* Directory.
    - For more detailed information about our *provider*s, you can call *Member Services* or visit our website at www.nhpri.org.
- Information about your coverage and rules you must follow in using your coverage.
    - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
    - If you have questions about the rules or restrictions, please call *Member Services*.
- Information about why something is not covered and what you can do about it.
    - If a medical service is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service from an *out-of-network provider*.
    - If you are not happy or if you disagree with a decision we make about what medical care is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an *appeal*. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an *appeal* if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)

- If you want to ask our plan to pay our share of a bill you have received for medical care, see Chapter 5 of this booklet.

Section 1.3 You have the right to be treated with respect and recognition of your dignity and right to privacy

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, *claim*s experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at *Member Services*. If you have a complaint, such as a problem with wheelchair access, *Member Services* can help.

Section 1.4 You have the right to participate with your providers in decision making regarding your health care

You have the right to make decisions about your health care. You can refuse treatment or procedures anytime you wish. But one day, you may be unable to make or voice your decisions. These documents help make your wishes known:

- A living will is a set of instructions. It says what should happen if you become seriously ill and are unable to communicate.
- Durable power of attorney lets another person make health care decisions for you. You choose who this person will be. It could be your spouse, a family member, or a friend.
- Advance directives explain the treatment you want if you become seriously ill or injured. Advance directives can be written or spoken.

Ask your *Primary Care Provider* (*PCP*) about these options. You also can find related forms at the Rhode Island Department of Health website:

http://www.health.ri.gov/lifestages/death/about/livingwill/

Section 1.5 You have the right to privacy of all records and communications to the extent required by law

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.

- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

Please review the information below very carefully:

This information describes how health information about you may be used and shared and how you can get this information.

When does Neighborhood share my health information with others?

We share your health information with others, without your approval to:

- Assist in your treatment, by talking with the doctors involved in your plan of care to decide what's best for you.

- Determine whether we will pay for the services provided to you, such as deciding if a health care service is *medically necessary*.

- Conduct our health care operations, which in-include things like quality improvement programs.

When may Neighborhood share my health information with others?

We may also use or disclose your information in the following situations without your consent:

- To public health authorities for the purpose of controlling disease.

- To authorities allowed by law to receive reports of child abuse or neglect. In addition, we may disclose to these authorities if we believe you have been a victim of abuse, neglect or domestic violence.

- To appropriate organizations to assist in disaster relief efforts.
- To health oversight agencies that license health care professionals, and that conduct investigations and inspections of health care professionals.
- To a person who may have been exposed by you to a communicable disease
- To report adverse reactions to medications, product defects, and other information, if required by the Food and Drug Administration.
- In the course of any legal action, in response to a court order or, sometimes in response to a subpoena, as long as you have been duly notified or attempts to notify you have been made according to law and the subpoena has not been withdrawn.
- To law enforcement authorities, as long as all applicable legal requirements are met.
- To a medical examiner, such as for identification purposes or determining the cause of death.
- To prevent or lessen a serious and imminent threat to the health or safety of a person or the public if we believe that the disclosure is necessary.
- To comply with workers' compensation laws and other similar programs.
- To you and the Secretary of the United States Department of Health and Human Services ("Secretary") to investigate or determine our compliance with the federal privacy regulations.
- In an *emergency*, we may also share your health information without your approval when we are required by law or public health authorities to do so.

Does Neighborhood need my approval before it shares my health information with others?

Except for the purposes listed above and those permitted or required by the government, Neighborhood will not share your information without your written approval. Even when you have given your approval, you can change your mind as long as you do so in writing before we have shared your information.

What are my health information rights?

You have the right to:

- Get a paper copy of this notice if you ask for it.

- Ask us to limit the way we share your information, although we are not required to agree to what you ask.
- Look at and get a copy of the health information we have about you, as provided by law.
- Ask us to change information we have about you in our member file. You must ask us in writing and tell us why you are asking for the change, although we are not required to agree to the change.
- Ask us to contact you in an alternative way. For example, you may ask us to contact you at work only.
- Take back your approval that we share your information. However, you can only do that if the information hasn't already been shared.
- Receive an accounting of when we shared your information, except if it was for payment, treatment or operations, or with your approval.

What are Neighborhood's duties?

Neighborhood uses many methods to protect your oral, written and electronic health information from illegal use or disclosure. We are required by law to:

- Keep your health information private.
- Provide you with this notice and follow the rules listed here.
- Let you know if we cannot agree to limit how we share your information.
- Agree to reasonable requests to contact you by alternative means or at alternative locations.
- Get your written approval to share your health information for reasons other than those listed above and permitted by law.

Not only do all the *provider*s in our network know that your information is private and confidential, but Neighborhood's employees know that too. We use training programs for our employees and policies and procedures supported by management oversight to ensure that our employees know the procedures they need to follow to make sure that your information - whether in oral, written or electronic format - is secure and safeguarded. Additionally, we have other vendors sign Business Associate Agreements that clearly outline their requirement to protect your information and our expectations concerning protecting your oral, written or electronic health information.

Neighborhood reserves the right to change its privacy practices. If our practices change, we will revise this notice and send it to all Neighborhood Members. The new practices would apply to all of the health information we have, including the health information we already have about you.

What if I have questions or need help with this?

If you need help understanding this notice or you want to exercise any of your rights stated within this notice, please contact Neighborhood *Member Services* at 1-800-459-6019.

What if I think Neighborhood shared my information incorrectly?

You may complain to the Neighborhood Privacy Officer by calling 1-800-963-1001 and asking for the Director of Organizational Development and Human Resources, or by writing to:

> Chief Privacy Officer, Attn: Director of Organizational Development and Human Resources, Neighborhood Health Plan of Rhode Island
> 299 Promenade Street
> Providence, Rhode Island 02908.

You also have the right to complain, in writing, to the Secretary of the United States Department of Health and Human Services. Please ask us if you need help doing that. Your benefits will not be affected if you make a complaint. Here is the address and phone number:

> Office for Civil Rights
> U.S. Department of Health and Human Services
> JFK Federal Building, Room 1875, Boston, MA 02203
> 1-866-627-7748

You can also contact Neighborhood's Compliance Hotline (1-800-826-6762) to report suspected incidents.

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

Section 1.6 You have the right to respectful, personal attention without regard to your race, national origin, gender, age, sexual orientation, religious affiliation, or preexisting conditions

What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about **discrimination**, call the Office for Civil Rights

If you believe you have been **treated unfairly or your rights have not been respected** due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it **about something else**?

If you believe you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

- You can **call *Member Services*** (phone numbers are printed on the back cover of this booklet).

Section 1.7 You have the right to obtain a second medical opinion for medical and surgical concerns

As a Neighborhood member, you have the right to receive a second opinion. This means you can see someone else if you do not think you should have the treatment or surgery your doctor recommends. You may want another doctor's opinion.

If the doctor you would like to see is not in our network, you will need approval from Neighborhood first. This is called *preauthorization*. *Preauthorization* is not required when you seek a second or third opinion from a doctor in our network. Call Neighborhood *Member Services* at 855-321-XCHG (855-321-9244) to find a doctor for a second or third opinion.

Section 1.8 You have the right to a candid discussion of appropriate or *medically necessary* treatment options for your conditions, regardless of cost or benefit coverage

You have the right to get full information from your doctors and other health care *provider*s when you go for medical care. Your *provider*s must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any *experimental* treatments.

- **The right to say "no.**" You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.

- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a *provider* has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 7 of this booklet tells how to ask the plan for a coverage decision.

Section 1.9 You have the right to voice complaints or appeals about Neighborhood or the care provided by its providers

If you have any problems or concerns about your *covered services* or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 7, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an *appeal* to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an *appeal*, or make a complaint – **we are required to treat you fairly.**

Section 1.10 You have the right to make recommendations about Neighborhood's Member Rights and Responsibilities policies

You can make recommendations about Neighborhood's Member Right and Responsibilities policies by calling *Member Services*.

SECTION 2 You have some responsibilities as a member of the plan

Section 2.1 Your responsibilities

Things you need to do as a member of the plan are listed below. If you have any questions, please call *Member Services* (phone numbers are printed on the back cover of this booklet). We're here to help.

When you enroll with NHPRI Exchange Health Plan, you agree to:

- Choose a *Primary Care Provider* (*PCP*) and Primary Care Site. Your *PCP* will coordinate all of your medical care. You may change your *PCP* at any time by calling Neighborhood *Member Services* 1-800-459-6019.
- Have all of your medical care provided by or arranged by a Neighborhood participating doctor.
- Carry your Neighborhood Identification Card with you and show it whenever you seek medical care.
- Provide, to the extent possible, information that Neighborhood and its practitioners and *provider*s need to care for you.
- Learn about your health problems and help plan treatment you and your *PCP* agree on.
- Follow the plans and instructions for care that you have agreed on with your *provider*s.
- Talk with your *PCP* about all specialty care. If you need a specialist, your *PCP* will work with you to make sure you get quality care.
- Call your *PCP* first for help if you have an urgent medical condition. If an *emergency* is life threatening, go immediately to the nearest Emergency Room or call 911. You (or a friend or relative) should contact your *PCP* the next day.
- Let Neighborhood know about changes to your name, home address, telephone number, marital status, number of *dependent*s or if you have other insurance coverage.
- Pay network providers the deductible, copayment, and the difference between the maximum benefit and our allowance (if any) that may apply to covered health care services

- Pay your premiums.
- Pay the cost of all excluded services and items.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

Neighborhood wants you to have quality health care services. These services should meet your needs. They should happen in a timely and respectful manner. We are committed to solving any concerns you may have about how the plan is operated, your benefits, or the quality of healthcare you receive from *network provider*s. To serve you better, Neighborhood has the following processes (each one described in detail below) depending on the type of concern you have.

- *Member* inquiry process
- *Member complaint* process
- Internal *appeal*s process (including fast *appeal*s)
- External review

Which process do you use? That depends on the type of problem you are having. The following descriptions will help you identify the right process to use.

SECTION 2 Member inquiry

Section 2.1 A member inquiry

An inquiry is any communication you make to the plan asking us to address a plan action, policy or procedure. This is an informal process used to resolve most Inquiries.

The inquiry process is not used to resolve concerns about the quality of care received by you from a *network provider* or an adverse determination (coverage denial based on medical necessity) – If your concern involves:

- The quality of care you received from a *network provider* - *Member Services* will refer your concern directly to our complaint process (see below).
- Denial of coverage - *Member Services* will refer your concern directly to our *appeal*s Process (see below).

Section 2.2 Making an Inquiry

Member inquiry process

Call *Member Services* at 1-800-459-6019 to discuss your concern. We will make every effort to resolve your concerns, and in most cases will respond by phone to you within 3 working days. If you tell us that you are not satisfied with decisions, or we were unable to resolve your issue, .you may choose to file a *complaint* or *appeal*. The process we use depends on the type of Inquiry that you made. If you do this, you will receive written acknowledgement and written resolution in accordance with the timelines outlined below.

SECTION 3 Complaint process

Section 3.1 A complaint

Member complaint

A *complaint* is a formal complaint about actions taken by Neighborhood or a Neighborhood Plan *provider*. The member complaint process does not apply to requests for a review of a denial of coverage. If you are seeking such a review, please see the "*Member appeals*" section below.

We have two types of *complaints*: administrative *complaints* and quality of care *complaints*. We describe the two types of *complaints* below.

Administrative *complaint*

An administrative *complaint* is a complaint about a Neighborhood employee, department, policy, or procedure, or about a billing issue. Examples of administrative complaints include the following:

- Respecting your privacy
    - Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
- Disrespect, poor customer service, or other negative behaviors
    - Has someone been rude or disrespectful to you?
    - Are you unhappy with how our *Member Services* has treated you?

- Do you feel you are being encouraged to leave the plan?

- Waiting times
  - Are you having trouble getting an appointment, or waiting too long to get it?
  - Have you been kept waiting too long by doctors or other health professionals? Or by our *Member Services* or other staff at the plan?
  - Have you been kept waiting too long on the phone, in the waiting room, or in the exam room?

- Cleanliness
  - Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

- Information you get from us
  - Do you believe we have not given you a notice that we are required to give?
  - Do you think written information we have given you is hard to understand?

Quality of Care Complaints

A quality of care *complaint* is a complaint about the quality of care or services that you have received. You may have concerns about your medical care. If so, you should discuss them directly with your *provider*. You may not be satisfied with your *provider*'s response or may not want to address your concerns directly with your *provider*. If so, you may contact *Member Services* to file a quality of care *complaint*.

Section 3.2 How and where to file a complaint

It is important that you contact us as soon as possible to explain your concern. *Complaint*s may be filed either verbally or in writing.

If you choose to file a *complaint* verbally, please call Neighborhood's *Member Services* at 1-800-459-6019. A *Member Services* Specialist will document your concern and forward it to an Grievance and Appeals Analyst in the Grievance and Appeals Unit.

To accurately reflect your concerns, you may want to put your *complaint* in writing.

Send written *complaint*s to:

Member Services Grievance and Appeals
Neighborhood Health Plan of Rhode Island
299 Promenade Street
Providence, RI 02908

Your explanation should include:

- Your name and address,
- Your Member ID number,
- Daytime home phone number ,
- A detailed description of your concern. This includes relevant dates, any applicable medical information, and *provider* names, and
- Any supporting documentation.

Release of Medical Records: We may request a signed Authorization to Release Medical Records form. This form authorizes *provider*s to release medical information to us. It must be signed and dated by you or your Authorized Representative. When signed by an Authorized Representative, appropriate proof of authorization to release medical information must be provided.)

If an Authorization to Release Medical Records form is not included with your *complaint*, *Member Services* will promptly send you a blank form. It is very important that you fill out and send us this form. This allows us to obtain medical information we will need to address your *complaint*. If we do not receive this form within 30 calendar days of the date we received your *complaint*, we may respond to your *complaint* without having reviewed relevant medical information. In addition, if we receive the form from you but your *provider* does not give us your medical records in a timely fashion, we will ask you to agree to extend the time limit for us to respond to your *complaint*. If we cannot reach agreement with you on a timeline extension, we may respond to your *complaint* without having reviewed relevant medical information.

Complaint resolution:

- If your *complaint* requires us to review your medical records, the review does not begin until we receive from you a signed "Authorization to Release Medical Information" form. We have a sixty (60) day review period from receipt of your medical information. If your

complaint does not require us to review your medical records, the 30 day calendar day period begins on the next working day following the day the *complaint* was received.

The time limits in this process may be waived or extended beyond the time. This would be done by mutual written agreement between you and Neighborhood.

SECTION 4 Internal appeals process

Section 4.1 An internal appeal

Internal appeal

What is an internal *appeal*? An internal *appeal* is a request for a review of a denial of coverage for a service or supply that has been reviewed and denied by Neighborhood based on:

- Medical necessity (an adverse determination); or
- A denial of coverage for a specifically excluded service or supply.

An *appeal* is a formal request by you for review of a Benefit Denial, an Adverse Determination, or a Retroactive Termination of Coverage – all as specifically defined as follows:

Medical *appeal*

Adverse Determination: A plan decision, based on a review of information provided, to deny, reduce, modify or terminate an admission, continued *inpatient* stay or the availability of any other health care services, for failure to meet the requirements for coverage based on: medical necessity; appropriateness of health care setting and level of care; or effectiveness. These are often known as medical necessity denials because in these cases the plan has determined that the service is not *medically necessary* for you.

Administrative *appeal*

- **Benefit Denial**:
    - A plan decision, made before or after you have obtained services, to deny coverage for a service, supply or drug that is specifically limited or excluded from coverage in this *Certificate of coverage*; or
    - A plan decision to deny coverage for a service, supply or drug because you are no longer eligible for coverage under the plan. (This means you no longer meet the plan's eligibility criteria.)
- **Retroactive Termination of Coverage**: A retroactive cancellation or discontinuance of enrollment as a result of the plan's determination that: you have performed an act,

practice or omission that constitutes fraud; or you have intentionally misrepresented a material fact with regard to the terms of the plan.

Section 4.2 Choosing to use the internal appeals process

Examples of situations when to use the *appeal*s process include the following:

- You are not getting certain medical care you want, and you believe that this care is covered by our plan.
- Our plan will not approve the medical care your doctor or other medical *provider* wants to give you, and you believe that this care is covered by the plan.
- You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.

The Neighborhood Grievance and Appeals Unit will coordinate a review of all of the information submitted upon *appeal*. That review will consider your benefits as detailed in this *Certificate of coverage*. You are entitled to two (2) levels of internal review.

Section 4.3 How and where to file an internal appeal

Internal appeal

It is important that you contact us as soon as possible to explain your concern. You have ninety (90) days from the date you were notified of the denial of benefit coverage, *claim* payment, or first level *appeal* denial to file an *appeal*. *Appeal*s may be filed either verbally or in writing.

To file a verbal *appeal*, call *Member Services*. A *Member Services* Specialist will document your concern and forward it to a Grievance and Appeals Analyst in the Grievance and Appeals Department. For verbal *appeal*s related to Mental Health or Chemical dependency, you must call 1-800-215-0058. If you file an oral *appeal*, we will write a summary of your *appeal* and send you a copy within 48 hours of receipt.

To reflect your concerns accurately, you may want to put your *appeal* in writing. Then, send it to:

Member Services Complaints and Appeals
Neighborhood Health Plan of Rhode Island
299 Promenade Street

Providence, RI 02908

Your explanation should include:

- Your name and address
- Your Member ID number
- A detailed description of your concern. This includes relevant dates, any applicable medical information, and *provider* names, and
- Any supporting documentation.

Plan acknowledgement of your *appeal*. Within five (5) calendar days of receipt of a written or verbal administrative or medical *appeal*, the Grievance and Appeals Unit will mail or call you to phone acknowledge of our receipt of the medical *appeal*.

Section 4.4 Medical records release

Release of Medical Records: We may request a signed Authorization to Release Medical Records form. This form authorizes *provider*s to release medical information to us. It must be signed and dated by you or your Authorized Representative. (When signed by an Authorized Representative, appropriate proof of authorization to release medical information must be provided.)

Section 4.5 How the medical appeal process works

We will review your medical *appeal* and make a decision, within 15 days. We will notify you by sending you a decision letter.

Who reviews *appeal*s?

First level *appeal*s of a medical necessity determination will be reviewed by a licensed *provider*: with the same licensure status as the ordering *provider* or a licensed *provider* or a licensed dentist; and who did not participate in any of the prior decisions on the case.

Second level *appeal*s will be reviewed by a licensed *provider* in the same or similar specialty as typically treats the medical condition, procedure or treatment under review.

A designated reviewer will review *appeal*s involving non-*covered services*. That person will be from the Grievance and Appeals and Department.

Appeal response letters

The letter you receive from Neighborhood will include identification of the specific information considered for your *appeal* and an explanation of the basis for the decision. Notification of the steps requested the next level of internal *appeal* or an external review by an External Appeals Agency, designated by the Rhode Island Department of Health, as appropriate.

Also, a first level adverse *appeal* determination letter will notify you that should you file a second level *appeal*, you have the right to: (1) inspect the *appeal* review file and; (2) add information prior to our reaching a final decision.

Finally, a second level adverse *appeal* determination letter will include: fee information for filing an external review; and a statement that if Neighborhood's decision is overturned by the external appeals agency, you will be reimbursed by NHRPI within sixty (60) days of the date you are notified of the overturn for your share of the *appeal* fee.

Section 4.5 A fast (expedited) appeal

Fast *appeal*

We recognize that there are circumstances that require a quicker turnaround than the fifteen (15) calendar days allotted for the standard *appeal*s process. A fast *appeal* determination is for services that have not yet been rendered (a pre-service review). Services that have already been rendered (retrospective review) are not eligible for fast (urgent) review.

We will expedite an *appeal*:

- When there is an ongoing service about to terminate or a service to be delivered imminently whereby a delay in treatment would seriously jeopardize your life and health or jeopardize your ability to regain maximum function.

- Additionally, we will expedite your *appeal* if a medical professional determines it involves emergent health care services (defined as medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition:

    - Placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy;

- Constituting a serious impairment to bodily functions; or
- Constituting a serious dysfunction of any bodily organ or part.

How and where can I file a fast (expedited) *appeal*?

If you feel your request meets the criteria cited above, you or your attending *provider* should contact *Member Services* at 1-800-963-1001.

Neighborhood will make a decision as expeditiously as your health condition might require, but no later than 72 hours after receipt of the request.

Section 4.6 How the administrative appeals process works

We will respond to your administrative *appeal* in writing within thirty (30) calendar days of our receipt of your administrative *appeal*. The determination letter will provide you with information regarding our determination.

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

SECTION 5 External review

Section 5.1 An external review

Neighborhood provides for an independent external review by an external appeal agency for final adverse determinations. These are decisions based on medical necessity.) The Rhode Island Department of Health has designated an external appeal agency that performs independent reviews of final adverse medical necessity decisions. The external review agency is not connected in any way with Neighborhood. Please note that *appeal*s for coverage of services excluded from coverage under your plan are not eligible for external review. This external *appeal* is voluntary. This means you may choose to participate in this level of *appeal*, or you may file suit in an appropriate court of law (Please see Legal Action, below).

Section 5.2 How and where to request an external review

To initiate this external *appeal*, you must send a letter to us within four months of the receipt of your second level adverse determination letter. In that letter, you must include:

- Any additional information that you would like the external review agency to consider; and
- Your share of the fee for this review will be no greater than $25. (Information regarding current external *appeal* fees will be included in second level adverse *appeal* determination letters.)
- Cost of the appeal will be born by Neighborhood

Within five (5) days of receipt of your written request and your share of the fee, Neighborhood will forward the complete review file, including the criteria utilized in making its decision, along with the balance of the fee to the external appeal agency.

For standard *appeal*s, the external appeal agency will complete its review and make a final determination within ten (10) business days. For *appeal*s determined to be for an emergent health care service, the external appeal agency will complete a review and make a final determination within two (2) business days of receipt.

The external appeal agency will provide notice to you and your *provider* of record of the outcome of the external *appeal*. The external review will be based on the following:

- The review criteria used by Neighborhood to make the internal *appeal* determination;
- The medical necessity for the care, treatment or service for which coverage was denied; and
- The appropriateness of the service delivery for which coverage was denied.

The decision of the external appeals agency is binding. However, any person who is not satisfied by a final decision of the external appeals agency is entitled to judicial review in a court of competent jurisdiction.

If the external appeals agency overturns Neighborhood's second level *appeal* decision, Neighborhood will reimburse you for your share of the *appeal* fee within 60 days of the notice of the decision. In addition, we will send you a written notice within five (5) business days of receipt of the written decision from the *appeal* agency. This notice will:

- Include an acknowledgement of the decision of the agency;
- Advise of any procedures that you need to take in order to obtain the requested coverage or services;
- Advise you of the date by which the payment will be made or the authorization for services will be issued by Neighborhood; and
- Include the name and phone number of the person at Neighborhood who will assist you with final resolution of *appeal*.

SECTION 6 Legal action

Section 6.1 Legal action

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

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

Under state law, you may not begin court proceedings prior to the expiration of sixty (60) days after the date you filed your *claim*. In no event may legal action be taken against us later than three (3) years from the date you were required to file the *claim*.

SECTION 7 Our right to withhold payments

Section 7.1 Our right to withhold payments

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

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

Chapter 8. Ending your Membership in the plan

SECTION 1 Introduction

Section 1.1 Ending your membership in our plan

Ending your Membership in Neighborhood Exchange Health Plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you want to leave.
- There are also limited situations where you do not choose to leave, but we may end your Membership. Section 3 tells you about situations when we may end your Membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your Membership ends.

SECTION 2 When you can end your membership in our plan

Section 2.1 If you decide to discontinue coverage

If you decide to discontinue coverage, we must receive your notice within 14 days to Neighborhood or the Exchange to end this agreement prior to the requested date of cancellation. If we do not receive your notice prior to the requested date of cancellation, you may be responsible for paying another month's *member* premium. This agreement will end for a covered *dependent* if the *dependent* no longer qualifies as an eligible *dependent*.

An enrolled *dependent*'s coverage ends when the *subscriber*'s coverage ends, or when the *dependent* no longer meets the definition of *dependent*, whichever occurs first. See Chapter 1, Section 2.3, "Continuing eligibility for *dependents*" for more information.

If you have any questions or would like more information on when you can end your Membership: you can call *Member Services* (phone numbers are printed on the back cover of this booklet

SECTION 3 When Neighborhood may end your membership in the plan

Section 3.1 When we may end your membership in the plan

Neighborhood may end your Membership in the plan if any of the following happen:

- Failure to pay premiums or contributions in accordance with the terms of the health insurance coverage

- Failure to make timely premium payments;

    - A grace period of ten (10) days will be granted for the payment of each Premium after the first Premium. During that grace period, this Contract will continue in force, subject to our right to cancel in accordance with the cancellation privileges of this Contract.

    - If any renewal Premium is not paid within the grace period, coverage may be reinstated in accordance with Rhode Island Statute 27-18-3(4).

    - If you are a member who receives advance payments of premium tax credit, you will have a 3-month grace period and we must provide you with advance notice that your payments are late, unless the *Exchange* has accepted the obligation to do so instead of Neighborhood.

    - For all other Members, we will give you notice of late payment and a 31-day grace period before your insurance by us will end.

- Performance of an act or practice that constitutes fraud or there is an intentional misrepresentation of material fact under the terms of the coverage;

- You no longer reside, live, or work in the service area. This applies to all Members equally and will not consider any health status-related factor;

- If coverage that is made available through an association and your Membership in the association (on the basis of which the coverage is provided) stops. This applies to all Members equally and will not consider any health status-related factor.

- Neighborhood ceases to offer coverage in accordance with subsections (c) and (d) of this section;

- If Neighborhood stops offering your particular type of health insurance coverage. In this case we will:

    - At least ninety (90) days prior to the date of discontinuation we provide notice of the discontinuation to each covered individual provided coverage;

    - Offer you the opportunity to purchase any other individual health insurance coverage currently being offered by Neighborhood; and

- Treat all Members equally and will not consider any health status-related factor.

- You are no longer eligible for coverage through the *Exchange*
- You become eligible for either or both parts of Medicare or under any other state or federal law providing for benefits similar to those provided by this Plan

*Note: Children are not required to maintain primary residence in the Service Area. However, care outside of the service area is limited to *emergency* or urgent care only.

Where can you get more information?

If you have questions or would like more information on when we can end your Membership:

- You can call ***Member Services*** for more information (phone numbers are printed on the back cover of this booklet).

Section 3.2 When a member is no longer eligible

Loss of Eligibility

Your coverage ends on the date you no longer meet the eligibility rules described in Chapter 3, Section 2

Note: Your coverage will terminate retroactively. This is done back to the date you are no longer eligible for coverage

Section 3.3 If you move out of the service area

What should you do if this happens?

If you are a *subscriber* or *spouse* and you move out of the Service Area, coverage ends on the date you move. Children are not required to maintain primary residence in the Service Area. However, care outside of the service area is limited to *emergency* or urgent care only.

Before you move, call *Member Services* to notify us of your move date. You may have kept a residence in the Service Area, but been out of the Service Area for more than 90 days. If this happens, coverage ends 90 days after the date you left the Service Area.

For more information about coverage available to you when you move out of the Service Area, contact *Member Services*.

Section 3.4 Membership termination for acts of physical or verbal abuse

We may terminate your coverage if you commit acts of physical or verbal abuse which: are unrelated to your physical or mental condition; pose a threat to any *provider*, any Neighborhood Health Plan Member, or Neighborhood Health Plan or any Neighborhood Health Plan employee.

Section 3.5 Membership termination for misrepresentation or fraud

We may terminate your coverage for misrepresentation or fraud during the first two years of coverage under this plan. If your coverage is terminated for misrepresentation or fraud, we may not allow you to re-enroll for coverage with us under any other plan (such as an employer's plan) or type of coverage (for example, coverage as a *dependent* or spouse).

What are acts of misrepresentation or fraud?

Examples of misrepresentation or fraud include:

- False or misleading information on your application;
- Enrolling as a *spouse* someone who is not your *spouse*;
- Receiving benefits for which you are not eligible;
- Keeping for yourself payments made by Neighborhood that were intended to be used to pay *provider*; or
- Allowing someone else to use your Member ID card.

Date of termination

If we terminate your coverage for misrepresentation or fraud, your coverage will end as of a later date chosen by us. During the first two years of coverage, we reserve the right to revoke coverage and deny payment of *claim*s retroactive to your *effective date* for any false or misleading information on your application. Should we decide to end your enrollment, we will provide at least thirty (30) days advance written notice.

You can also look in Chapter 7, Section 3 for information about how to make a complaint. We will pay for all *covered services* you received between: your *effective date*; and your termination date, as chosen by us. We may retroactively terminate your coverage back to a date no earlier than your *effective date*. We may use any Premium you paid for a period after your termination date to pay for any *covered services* you received after your termination date.

The Premium may not be enough to pay for that care. In this case, Neighborhood, at its option, may: pay the *provider* for those services and ask you to pay us back; or not pay for those services. In this case, you will have to pay the *provider* for the services.

SECTION 4 HIPAA certificate of creditable coverage

Section 4.1 Certificate of creditable coverage

HIPAA certificate of creditable coverage

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

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

SECTION 5 Continuation of coverage

Section 5.1 Continuation of coverage

Coverage is guaranteed renewable, and Neighborhood may non-renew or cancel coverage under the Plan only for nonpayment of premiums, fraud, market exit, movement outside of service area, or if the member is no longer eligible.

Chapter 9. Other plan provisions

SECTION 1 General legal provisions

Section 1.1 Subrogation

Neighborhood's right of subrogation

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

You may have a legal right to recover some or all of the costs of your health care from someone else (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. This includes such costs to any *dependent* covered under this plan.

Neighborhood may cover health care costs for which a Third Party is responsible. In this case, we may require that Third Party to repay us the full cost of all such benefit provided by this plan. Our rights of recovery apply to any recoveries made by you or on your behalf from any source.

This includes, but is not limited to:

- Payments made by a Third Party;
- Payments made by any insurance company on behalf of the Third Party;
- Any payments or rewards under an uninsured or underinsured motorist coverage policy;
- Any disability award or settlement;
- Medical payments coverage under any automobile policy;
- Premises or homeowners' medical payments coverage;
- Premises or homeowners' insurance coverage; and
- Any other payments from a source intended to compensate you for Third Party injuries.

We have the right to recover those costs in your name. We can do this with or without your consent, directly from that person or company. 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.

Personal injury protection/med pay benefits

You may be entitled to benefits under your own or another individual's automobile coverage, regardless of fault. These benefits are commonly referred to as Personal Injury Protection (PIP) and Medical Payments (MedPay) benefits. To the extent permitted under applicable state law, our coverage is secondary to both PIP and MedPay benefits. If we pay benefits before PIP or MedPay benefits have been exhausted, we may recover the cost of these benefits as described above.

Neighborhood's right of reimbursement

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

This provision applies in addition to the rights described above. You may recover money by suit, settlement, or otherwise. If this happens, you are required to reimburse us for the cost of health care services, supplies, medications, and expenses for which we paid or will pay. This right of reimbursement starts when (1) we have provided health care benefits for expenses where a Third Party is responsible and (2) you have recovered any amounts from any sources. This includes, but is not limited to:

- Payments made by a Third Party;
- Payments made by any insurance company on behalf of the Third Party;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any disability award or settlement;
- Medical payments coverage under any automobile policy;
- Premises or homeowners' medical payments coverage;
- Premises or homeowners' insurance coverage; and
- Any other payments from a source intended to compensate you, where a Third Party is responsible.

We have the right to be reimbursed up to the amount of any payment received by you. This is regardless of whether: (a) all or part of the payment to you was designated, allocated, or characterized as payment for medical expenses; or (b) the payment is for an amount less than that necessary to compensate you fully for the illness or injury.

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 health care services and supplies, and expenses, that we paid or will pay for your illness or injury;
- 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 benefits associated with Third Party responsibility;
- To do nothing to prejudice our rights as described 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 all benefits provided by this plan;
- To serve as a constructive trustee for the benefit of the plan over any settlement or recovery funds received as a result of Third Party responsibility;
- That we may recover the full cost of all benefits 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 without our prior express written consent; and

- That in the event you or your representative fails to cooperate with Neighborhood, you will be responsible for all benefits provided by this plan in addition to costs and attorney's fees incurred by Neighborhood in obtaining repayment.

Workers' compensation

Employers provide workers' compensation insurance for their employees. Employers do this to protect them in case of work-related illness or injury.

If you have a work-related illness or injury, you and your employer must ensure that all medical *claim*s related to the illness or injury are billed to your employer's workers' compensation insurer. We will not provide coverage for any injury or illness for which it determines that the *member* is entitled to benefits pursuant to: (1) any workers' compensation statute or equivalent employer liability; or (2) indemnification law. This is the case whether or not the employer has obtained workers' compensation coverage as required by law.

We may pay for costs of health care services or medications for any work-related illness or injury. If we do this, we have the right to recover those costs from you, the person, or company legally obligated to pay for such services, or from the *provider*. If your *provider* bills services or medications to us for any work-related illness or injury, contact the <Liability and Recovery Department Name >at <TELEPHONE NUMBER>

Subrogation Agent

We may contract with a third party to administer subrogation recoveries. In such case, that subcontractor will act as our agent.

Constructive trust

By accepting benefits from Neighborhood, you agree that if you receive any payment from any responsible party as a result of an injury, illness, or condition, you will serve as a constructive trustee over the funds that constitute such payment. This is the case whether the payment of such benefits is made to you directly, or made on your behalf (for example, to a *provider*).Failure to hold the funds in trust will be deemed a breach of your fiduciary duty to Neighborhood.

Section 1.2 Amendments to this policy

We reserve the right, without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy. Any provision of the Policy which is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the

Policy is delivered) is amended to conform to the minimum requirements of such statutes and regulations. No other change may be made to the Policy unless it is made by an Amendment or Rider signed by one of our officers. All of the following conditions apply:

- Amendments to the Policy are effective 31 days after we send written notice.
- Riders are effective on the date we specify.
- No agent has the authority to change the Policy or to waive any of its provisions.

No one has authority to make any oral changes or amendments to the Policy

Section 1.3 Genetic information

We do 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 individual or family Members of an individual before, in connection with enrollment, or at any time for underwriting purposes.

Section 1.4 Our rights to make payments and recover overpayments

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

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

Section 1.5 Limitation of action

You cannot bring any legal action against us to recover reimbursement prior to the expiration of sixty days after a request for benefits has been filed and no such action can be brought at all unless brought within three years from the expiration of time to submit a request for benefits.

Section 1.6 Circumstances beyond Neighborhood's control

Neighborhood will not be responsible for a failure or delay in arranging for the provision of services in cases of circumstances beyond the reasonable control of Neighborhood. Such circumstances include, but are not limited to: major disaster; epidemic; strike; war; riot; and civil insurrection. In such circumstances, we will make a good faith effort to arrange for the provision of services. In doing so, we will take into account the impact of the event and the availability of *network provider*s.

Section 1.7 Patient protection disclosure

You do not need prior authorization from Neighborhood or from any other person (including a *Primary Care Provider*) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining *preauthorization* for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specializes in obstetrics or gynecology, contact *Member Services* or see our Web site at www.Neighborhood.org.

SECTION 2 Your relationship with us

We do not provide medical services or make treatment decisions. This means:

- We do not decide what care you need or will receive. You and your Physician make those decisions.
- We communicate to you decisions about whether the Enrolling Group's Benefit plan will cover or pay for the health care that you may receive.
- The plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

SECTION 3 Our relationship with network providers

The relationships between us and network *provider*s are solely contractual relationships between independent contractors. Network *provider*s and are not our agents or employees. We and our employees are not agents or employees of *network provider*s. We do not provide health care services or supplies. We do not practice medicine. We arrange for health care *provider*s to be part of a Network and we pay Benefits. Network *provider*s are independent *provider*s who run their own offices and facilities. Our credentialing process confirms public information about the *provider*s' licenses and other credentials. It does not assure the quality of the services provided. They are not our employees and we do not have any other relationship with Network *provider*s. We are not liable for any act or omission of any *provider*.

SECTION 4 Your relationship with network providers

The relationship between you and any *provider* is that of *provider* and patient.

- You are responsible for choosing your own *provider*.
- You are responsible for paying, directly to your *provider*, any copayments, coinsurance, any annual *deductible* and any amount that exceeds eligible expenses.
- You are responsible for paying, directly to your *provider*, the cost of any non-Covered Service.
- You must decide if any *provider* treating you is right for you. This includes Network *provider*s you choose and *provider*s to whom you have been referred.
- You must decide with your *provider* what care you should receive.
- Your *provider* is solely responsible for the quality of the services provided to you.

SECTION 5 How we coordinate your Benefits when you are covered by more than one Plan

Section 5.1 Introduction to Coordination of Benefits (COB)

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

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

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

Section 5.2 Definitions

The following definitions apply to Section 5:

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

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

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

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

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

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

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

Secondary plan means a *plan* which is not a *primary plan*.

Section 5.3 When you have more than one agreement with NHPRI

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

Section 5.4 How we Coordinate your benefits when you are covered by more than one plan

When You Are Covered By More Than One Insurer

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

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

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

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

Non-Dependent/Dependent - If you are covered under a plan and you are the main subscriber, the benefits of that plan will be determined before the benefits of a plan which covers you as a dependent. If, however, you are a Medicare beneficiary, then, in some instances, Medicare will be Secondary and the plan which covers you as the main subscriber or as a dependent will provide the benefits first.

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

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

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

- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse of the parent with custody of the child; AND
- Finally, the plan of the parent not having custody of the child.

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

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

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

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

In general, if you use more benefits than you are covered for during a benefit period, the following formula is used to determine coverage:

The insurer covering you first will cover you up to its allowance. Then, the other insurer will cover any allowable benefits you use over that amount. It will never be more than the total amount of coverage that would have been provided if benefits were not coordinated.

Maximum benefits paid by first insurer + Any remaining allowable expense paid by other insurer = **Total Benefits Paid.**

Chapter 10. Definitions of important words

Adoptive child – A *child* is an *adoptive child* as of the date he or she:

- Is legally adopted by the *subscriber*; or
- Is placed for adoption with the *subscriber*. This means that the *subscriber* has assumed a legal obligation for the total or partial support of a *child* in anticipation of adoption. If the legal obligation ceases, the *child* is no longer considered placed for adoption.

We consider a foster child an *Adoptive Child* as of the date of placement for adoption.

Appeal – An *appeal* is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already received. You may also make an *appeal* if you disagree with our decision to stop services that you are receiving. For example, you may ask for an *appeal* if we do not pay for an item or service you think you should be able to receive. Chapter 7 explains *appeal*s, including the process involved in making an *appeal*.

Balance billing – A situation in which a *provider* (such as a doctor or hospital) bills a patient more than the plan's cost-sharing amount for services. You only have to pay the plan's cost-sharing amounts when you get services covered by our plan. We do not allow *provider*s to "balance bill" you. See Chapter 4, Section 1.4 for more information about *balance billing*.

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

Certificate of Coverage (COC) --This document, and any future amendments, which describes the health benefits under this contract.

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

Chemical dependency – The chronic abuse of alcohol or other drugs characterized by:

- Impaired functioning;
- Debilitating physical condition;
- The inability to keep from or reduce consuming the substance; or

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

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

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

Child --The following individuals until their 26th birthday:

- The *subscriber*'s or *spouse*'s natural child, stepchild, or *Adoptive Child* who qualifies as a *dependent* for federal tax purposes; or

- Any other *child* for whom the *subscriber* has legal guardianship.

Claim – A request that benefits of a plan be provided or paid.

COBRA – The Consolidated Omnibus Budget Reconciliation Act passed by Congress in 1986. This law provides continuation of individual health plan coverage that would otherwise have ended. COBRA gives certain former employees, retirees, spouses, and *dependent*s the right to temporary continuation of health coverage at individual rates.

Coinsurance – An amount you may be required to pay as your share of the cost for services. *Coinsurance* is usually a percentage (for example, 20%).

Contract year – A twelve (12) month period.

Copayment – An amount you may be required to pay as your share of the cost for a covered service or supply, like a doctor's visit, hospital *outpatient* visit, or a prescription. A *copayment* is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription.

Cost Sharing – The cost you pay for *covered services*. This amount may consist of *deductible*s, copayments, and/or coinsurance.

Covered service – The services and supplies for which we will pay. They must be:

- Described in Chapter 4 of this Certificate (They are subject to the "Benefits not covered by the plan" section in Chapter 4.); and

- *Medically necessary*.

These services include *medically necessary* coverage of pediatric specialty care (this includes mental health care) by *provider*s with recognized expertise in specialty pediatrics.

Covered services do not include any tax, surcharge, assessment, or other similar fee imposed under any state or federal law or regulation on any *provider*, *member*, service, supply, or medication.

Custodial care –

- Care provided primarily to assist in the activities of daily living. Examples include bathing, dressing, eating, and maintaining personal hygiene and safety;
- Care provided primarily for maintaining the *member*'s or anyone else's safety, when no other aspects of treatment require an acute hospital level of care;
- Services that could be provided by people without professional skills or training; or
- Routine maintenance of colostomies, ileostomies, and urinary catheters; or
- Adult and pediatric day care.

In cases of mental health care or substance abuse care, *inpatient* care or intermediate care provided primarily:

- For maintaining the *member*'s or anyone else's safety; or
- For the maintenance and monitoring of an established treatment program,
- When no other aspects of treatment require an acute hospital level of care or intermediate care.

Note: *Custodial care* is not covered.

Deductible – The amount that you must pay each *contract year* before our plan begins to pay for certain covered health care services. For example, if your *deductible* is $1000, we won' pay anything until you have met your $1000 *deductible* for covered health care services subject to the *deductible*. The *deductible* may not apply to all services.

Dependent --The *subscriber*'s spouse, *child*, or *disabled dependent.*

Developmental Services – Therapies, typically provided by a qualified professional using a treatment plan intended to lessen deficiencies in normal age appropriate function. The

therapies are generally meant to limit deficiencies related to injury or disease that have been present since birth. This is true even if the deficiency was detected during a later developmental stage. The deficiency may be the result of injury or disease during the developmental period. *Developmental services* are applied for sustained periods of time to promote acceleration in developmentally related functional capacity. This agreement does not cover *developmental services* unless specifically listed as covered.

Disabled dependent - The *subscriber*'s or spouse's natural *child*, step*child*, or *adoptive child* of any age that:

- Is permanently physically or mentally disabled, or has a disability which can be expected to result in death, or can be expected to last for a period of not less than 12 months; and
- Is financially dependent on the *subscriber*.

Durable Medical Equipment -- Devices or instruments of a durable nature that:

- Are reasonable and necessary to sustain a minimum threshold of independent daily living;
- Are made primarily to serve a medical purpose;
- Are not useful in the absence of illness or injury;
- Can withstand repeated use; and
- Can be used in the home.

Effective Date -- The date, according to our records, when you become a *member* and are first eligible for *covered services*.

Emergency -- An illness or medical condition, whether physical, behavioral, related to substance abuse, or mental, that manifests itself by symptoms of sufficient severity (this includes severe pain.) that the absence of prompt medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in:

- Serious jeopardy to the physical and / or mental health of a *member* or another person (or with respect to a pregnant *member*, the *member*'s or her unborn *child*'s physical and/or mental health); or
- Serious impairment to bodily functions; or

- Serious dysfunction of any bodily organ or part; or

- With respect to a pregnant woman who is having contractions, inadequate time to effect a safe transfer to another hospital before delivery, or a threat to the safety of the *member* or her unborn *child* in the event of transfer to another hospital before delivery.

Some examples of illnesses or medical conditions requiring *emergency* care are severe pain, a broken leg, loss of consciousness, vomiting blood, chest pain, difficulty breathing, or any medical condition that is quickly getting much worse

Eligible person – Is explained in Section 2.1. See Section 2.1 for a detailed description of who is eligible to enroll as a *dependent* under this agreement.

Exchange – The Rhode Island Health Benefits *Exchange* as originally established by Executive Order Number 11-09 to enable people to easily compare health insurance options, learn if they qualify for tax credits, and sign up for health insurance.

Experimental or investigative -- A service, supply, treatment, procedure, device, or medication (collectively "treatment") is considered *experimental* or *investigative* if any of the following apply:

- The drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished or to be furnished; or

- The treatment, or the "informed consent" form used with the treatment, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or federal law requires such review or approval; or

- Reliable evidence shows that the treatment is under study to determine its safety, efficacy, toxicity, maximum tolerated dose, or its efficacy as compared with a standard means of treatment or diagnosis; or

- Evaluation by an independent health technology assessment organization has determined that the treatment is not proven safe and/or effective in improving health outcomes or that appropriate patient selection has not been determined; or

- The peer-reviewed published literature regarding the treatment is predominantly non-randomized, historically controlled, case controlled or cohort studies; or there are few or no well-designed randomized, controlled trials.

Family coverage --Coverage for a *subscriber* and his or her *dependent*s.

Free-Standing ambulatory surgi-center – A state licensed facility which is equipped to surgically treat patients on an *outpatient* basis.

Complaint - A type of complaint you make about us or one of our *network provider*s, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Habilitative services – Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a *child* who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of *inpatient* and/or *outpatient* settings.

Home Health Aide – A *home health aide* provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). *Home health aides* do not have a nursing license or provide therapy.

Inpatient – A patient admitted to a hospital or other health care facility. The patient must be admitted at least overnight.

Maximum benefit – The total benefit allowed under this plan for covered health care services for a particular condition or service.

Out-of-pocket maximum – The most that you pay *out-of-pocket* during the calendar year for *covered services*. Unless otherwise indicated, we will pay up to 100% of our allowance for the rest of the *contract year* once you have met the maximum *out-of-pocket* expense,

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

Medically Necessary - means services or supplies which, under the provisions of this Agreement, are determined to be:

1. appropriate and necessary for the symptoms, diagnosis, treatment or maintenance of a Member's health;
2. provided for preventative care, or for diagnosis or direct care and treatment of a Member's medical condition or mental health status;
3. within standards of good professional practice within the applicable organized professional community;
4. not primarily for the convenience of the Member, the Member's physician or another health care provider; and
5. the most appropriate supply or level of service that can be provided safely.

For inpatient hospital services, this means that acute care as an inpatient is necessary due to the kind of services the Member is receiving or the severity of the Member's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensive medical setting.

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

Member (member of our plan, or "plan member") – A person who is eligible to get *covered services*, who has enrolled in our plan.

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, *complaint*s, and *appeal*s.

Network *provider* (Network) – A *provider* that has entered into an agreement with us.

Non-network *provider* (non-network) – A *provider* that has not entered into an agreement with us or another Neighborhood plan of another state.

Out-of-network *provider* or out-of-network facility – A *provider* or facility with which we have not arranged to coordinate or provide *covered services* to *member*s of our plan.

Out-of-pocket costs – See the definition for "cost sharing" above. A member's cost-sharing requirement to pay for a portion of services received is also referred to as the member's "*out-of-pocket*" cost requirement.

Outpatient – A patient receiving ambulatory care at a hospital or other health care facility. The patient is not admitted overnight.

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

Preauthorization is the approval that you must seek before receiving certain covered health care services. Selected prescription drugs bought at a pharmacy require prescription drug *preauthorization*. *Preauthorization* ensures that services are *medically necessary* and performed in the most appropriate setting. *Network providers* are responsible for obtaining *preauthorization* for all applicable covered health care services. You are responsible for obtaining *preauthorization* when the *provider* is *non-network*. If you do not obtain *preauthorization* and the services are determined to be not *medically necessary* or the

setting in which the services were received is determined to be inappropriate, we will not cover these services/ facilities.

- You may ask for *preauthorization* by telephoning us. For covered health care services (other than behavioral health services), call our *Member Services* Department at 1-800-963-1001.

- For behavioral health services (mental health and chemical dependency) call 1-800-215-0058.

- We encourage you to contact us at least two (2) working days before you receive any covered health care service for which *preauthorization* is recommended.

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

Premium – The total monthly cost of individual or family coverage that the *subscriber* pays to Neighborhood

Preventive care services – Covered health care services performed to prevent the occurrence of disease.

Primary Care *Provider* ("PCP") – A *network provider* who provides primary care services (including family practice, general practice, internal medicine, obstetrics and gynecology, and/or pediatrics), manages routine health care needs, and has been identified as the *Primary Care Provider* for one or more members.

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

These individuals include:

- Midwives;

- Certified registered nurse practitioners;

- Psychiatric and mental health nurse clinical specialists practicing in collaboration with or in the employ of a physician licensed in Rhode Island;

- Counselors in mental health; and

- Therapists in marriage and family practice.

Rehabilitation services – These services include physical therapy, speech and language therapy, and occupational therapy.

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

The services must be:

- Consistent with the nature and severity of illness;
- Be considered safe and effective for the patient's condition; and
- Be used to restore function.

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

Semi-private room – A hospital room with two or more patient beds.

***Skilled* Nursing Facility (SNF) Care** – *Skilled* nursing care and *rehabilitation* services provided on a continuous, daily basis, in a *Skilled Nursing Facility*. Examples of *Skilled Nursing Facility* care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Skilled -- A type of care that is *medically necessary*. This care must be provided by, or under the direct supervision of, licensed medical personnel. *Skilled* care is provided to achieve a medically desired and realistically achievable outcome.

Spouse -- The *subscriber*'s legal *spouse*, according to the law of the state in which you reside.

Spouse also includes the spousal equivalent of the *subscriber* who is the registered Domestic Partner, civil union partner, or other similar legally recognized partner of the *subscriber* who resides in a state or municipal jurisdiction that provides such legal recognition/spousal equivalent rights.

Subscriber - The person:

- Who enrolls in NHPRI Exchange Health Plan and signs the membership application form on behalf of himself or herself and any *dependent*s; and

- In whose name the Premium is paid.

Urgent Care Center – A health care center physically separate from a hospital or other institution with which it is affiliated. It may also mean an independently operated and owned health care center. These centers are also referred to as "walk-in centers".

[Note: this is the back cover for the Certificate of Coverage]

Neighborhood Individual Plan *Member Services*

CALL	855-321-XCHG (855-321-9244) Calls to this number are free. *Member Services* Specialists are available Monday through Friday 8:30 a.m. – 5:00 p.m. *Member Services* also has free language interpreter services available for non-English speakers.
TTY	401-459-6690 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.] Calls to this number are free. 8:30 a.m. – 5:00 p.m.
FAX	401-459-6021
WRITE	Neighborhood Health Plan of Rhode Island 299 Promenade Street Providence, Rhode Island 02908
WEBSITE	www.NHPRI.org

State: Rhode Island **Filing Company:** Neighborhood Health Plan of Rhode Island
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: Neighborhood - Individual Market Product
Project Name/Number: NHPRI Health Exchange 2014 - Individual Market/NHPRI Individual Market 2

Note To Reviewer

Created By:

Arthur Greenwood on 05/02/2013 12:39 PM

Last Edited By:

Arthur Greenwood

Submitted On:

05/02/2013 01:04 PM

Subject:

Waiver Request from Neighborhood Health Plan of Rhode Island Regarding Financial Capacity Limits

Comments:

Dear Commissioner Koller, et al:

Attached please find Neighborhood's request for waiver regarding financial capacity limits.

Please direct any questions to Clark Phillip at 401-459-6611.

Sincerely,
Art Greenwood

To: Christopher Koller, Commissioner, State of RI, Office of the Health Insurance Commissioner

CC: Herb Olsen, Executive Counsel, State of RI, Office of the Health Insurance Commissioner
Patrick Tigue, Principal Policy Associate, State of RI, Office of the Health Insurance Commissioner
and Sam Salganik, Legal Counsel, Health Benefits Exchange, Office of the Governor, State of Rhode Island

From: Clark Phillip, Chief Financial Officer, Neighborhood Health Plan of RI

Subject: Waiver Request from Neighborhood Health Plan of Rhode Island Regarding Financial Capacity Limits

Date: May 1, 2013

Neighborhood Health Plan of Rhode Island (Neighborhood) is requesting permission under 42 USC § 300gg–1(d)- Guaranteed availability of coverage, and any other applicable authority, based on the health plan's financial capacity limits. The request applies to the plans offered by Neighborhood under RI's Health Benefits Exchange.

Specifically, Neighborhood is requesting from the Office of the Health Insurance Commissioner, the applicable State authority, permission under the guaranteed availability of coverage requirements of 42 USC § 300gg–1 (d)(A) and (B) to enroll only RI Health Benefit Exchange participants who are at or below 250% of the federal poverty limit because Neighborhood does not presently have the financial reserves necessary to underwrite additional coverage of a broad population. . In doing so, Neighborhood will comply with the requirements of section (B) and will apply the permission uniformly to all individuals in the individual market at the Silver and Gold actuarial levels consistent with applicable State law and without regard to the claims experience of those individuals (and their dependents) or any health status-related factor relating to such individuals and dependents.

Neighborhood is seeking this permission based on (d) Application of financial capacity limits, because the health plan must limit its current and future risk exposure resulting from participation in the RI Health Benefits Exchange. Presently, Neighborhood only serves a Medicaid population under the State of RI's Medicaid managed care programs. As such, Neighborhood has financial capacity concerns resulting in this waiver request.

Neighborhood recognizes RI state law, RIGL section 42-14.5(1), obligates the Commissioner to "guard the solvency of health insurers". We agree to conform to the state's ongoing financial reporting and monitoring requirements of Neighborhood's financial condition under the authority of Title 27 and the Department of Business Regulation financial reporting regulations, on behalf of OHIC.

Should you have any questions about this request, please do not hesitate to contact me at (401) 459-6611 or cphillip@nhpri.org.

Note To Reviewer

Created By:

Arthur Greenwood on 05/01/2013 11:43 AM

Last Edited By:

Arthur Greenwood

Submitted On:

05/01/2013 11:43 AM

Subject:

Requested 5-1 Supplemental Rate and Actuarial Memorandum

Comments:

Dear Reviewers:

Attached please find the requested 5-1 Supplemental Rate and Actuarial Memorandum assuming populations include the greater than 250 FPL populations.

Please contact Art Greenwood at 459-6685 with questions regarding this infomation.

Sincerely,
Art Greenwood

State: Rhode Island **Filing Company:** Neighborhood Health Plan of Rhode Island
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: Neighborhood - Individual Market Product
Project Name/Number: NHPRI Health Exchange 2014 - Individual Market/NHPRI Individual Market 2

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April 30, 2013

Mr. T. Clark Phillip
Chief Financial Officer
Neighborhood Health Plan of Rhode Island
299 Promenade Street, Providence, RI 02908

RE:ACTUARIAL MEMORANDUM–INDIVIDUAL RHODE ISLAND EXCHANGE PRODUCTS

Dear Clark:

Milliman, Inc. (Milliman) was retained by Neighborhood Health Plan of Rhode Island (NHPRI) to develop premium rates and corresponding Actuarial Memoranda for Individual products to be marketed and sold through the Rhode Island Health Benefit Exchange (RIHBE). After submitting the required information, OHIC requested that a modified version of the Individual Market filing be provided. This modified version reflects NHPRI offering products to all income levels, rather than just those below 250% of the Federal Poverty Level (FPL). The required filings for these products are enclosed within this letter. This includes Rate Filing Justification Parts I and III, the 2013 Rate Review Process OHIC Template, and the Rhode Island actuarial memorandum. The same actuarial memorandum will serve as Rate Filing Justification Part III and as the Rhode Island state memorandum.

LIMITATIONS

The information contained in this letter has been provided solely for NHPRI. It is our understanding that the enclosures provided with this letter will be filed with the Rhode Island Office of the Health Insurance Commissioner (OHIC), the Rhode Island Health Benefit Exchange (RIHBE), and with the Centers for Medicare and Medicaid Services (CMS). This letter and the enclosures may not be distributed to any other party without the prior written consent of Milliman.

To the extent that the information contained in this letter and the attached enclosure is provided to third parties, the information should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling, or be advised by someone with the appropriate expertise, so as not to misinterpret the data presented.

Although Milliman may consent to the distribution of this letter to third parties, Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for NHPRI by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other third parties receiving this letter must rely upon their own experts in drawing conclusions about the results that have been presented in this letter. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work.

The premium rates and rating factors in the actuarial memorandum were developed from information contained in the ***Milliman Health Cost Guidelines***^{TM} (HCGs), other internal information, and from information provided by NHPRI. The memorandum does not guarantee that the rates will be adequate. Rather, the filing shows that the rates will be adequate if the assumptions underlying their development are realized.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and Neighborhood Health Plan of Rhode Island dated August 19, 2005.

DATA RELIANCE

In developing the premium rates and the actuarial memoranda, we relied on data and other information provided by NHPRI. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet the qualification standards for performing the analyses in this report.

Please contact me at 317-524-3513 with any questions or comments.

Sincerely,

Electronic Signature

Jeremy D. Palmer, FSA, MAAA
Principal and Consulting Actuary

JDP/lrb
Enclosure

Milliman

NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND

Individual Market Products
Actuarial Memorandum

I. SCOPE AND PURPOSE

Milliman, Inc. (Milliman) has been retained by Neighborhood Health Plan of Rhode Island (NHPRI) to prepare the premium rates and actuarial memorandum for Individual market products to be offered on the Rhode Island Health Benefit Exchange (RIHBE).

This document contains the Part III Actuarial Memorandum for NHPRI's Individual block of business, effective January 1, 2014. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template. This actuarial memorandum will also serve as the memorandum to support the 2013 Rate Review Process OHIC Template. The memorandum is intended to demonstrate that the premiums for these products are reasonable in relation to the benefits provided and to demonstrate compliance with regulatory authority. This memorandum may not be appropriate for any other purpose.

This actuarial memorandum has been prepared to be included in NHPRI's rate filings and is intended for use by the State of Rhode Island Office of the Health Insurance Commissioner (OHIC), the Rhode Island Health Benefit Exchange (RIHBE), the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of NHPRI's filings. However, we recognize that this certification may become a public document. Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this actuarial memorandum prepared for NHPRI by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

The memorandum does not guarantee that the rates will be adequate. Rather, the filing shows that the rates will be adequate if the assumptions underlying their development are realized.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

II. GENERAL INFORMATION

General Information related to NHPRI and the policies applicable to this actuarial memorandum are made available below.

A. Company Identifying Information

- Company Legal Name: Neighborhood Health Plan of Rhode Island
- State: The State of Rhode Island has regulatory authority over these policies
- HIOS Issuer ID: 77514
- Market: Individual
- Effective Date: January 1, 2014

B. Company Contact Information

- Primary Contact Name: Mr. T. Clark Phillip, CPA, Chief Financial Officer
- Primary Contact Telephone Number: (401) 459-6611
- Primary Contact Email Address: cphillip@nhpri.org

III. PROPOSED RATE INCREASE

Not applicable. The proposed rates within this actuarial memorandum are for new products that are intended to be offered on the RIHBE. NHPRI currently does not offer any products in the commercial health insurance market. As such, there are no rate adjustments being proposed.

IV. EXPERIENCE PERIOD PREMIUM AND CLAIMS

Not applicable. NHPRI currently does not offer any products in the commercial health insurance market. Because of this, no relevant experience based premium and/or claims data is available. The premium rates and corresponding factors proposed in this memorandum are based on a manual rate development process.

V. BENEFIT CATEGORIES

Not applicable. As no relevant data was available for the purpose of developing premium rates, experience data was not summarized by benefit category. The premium rates and corresponding factors proposed in this memorandum are based on a manual rate development process.

VI. PROJECTION FACTORS

Not applicable. Factors were not developed for the purpose of projecting experience period allowed claims, since no experience data was available. The premium rates and corresponding factors proposed in this memorandum are based on a manual rate development process. Assumptions for items such as morbidity changes, demographic changes, and trend were considered in developing manual rates as described in Section VII.

VII. CREDIBILITY MANUAL RATE DEVELOPMENT

NHPRI currently does not offer any products in the commercial health insurance market, which results in no experience data being available. For this reason, the premium rates and corresponding factors proposed in this memorandum are solely based on the manual rate development process.

In order to estimate premium rates for NHPRI products, the following steps were performed. These steps outline the premium development process including Population Assumptions (including morbidity and pent-up demand), Claim Costs, Administrative Expenses, Risk Adjustment Transfer, and Federal Transitional Reinsurance. While some of these items may fall outside of the scope of manual rate development, it is important to understand the process in its entirety.

A. Step 1: Project Statewide Market Members and Health Status by Population Cohort

We anticipate shifts in the insured population when the Rhode Island Health Benefit Exchange opens in 2014. We projected Rhode Island statewide members and their health status to help determine NHPRI's share of the market, the morbidity of their members, and NHPRI's risk adjustment receipts or payments.

For the purpose of projecting Rhode Island membership, a population projection model developed by Milliman's Indianapolis Health Practice was utilized (the Model). This model estimates the calendar year 2011 insurance market population and applies assumptions in order to project the developed population to future years. Estimated insurance market population counts are divided into cohorts that represent a combination of age, gender, household income (measured as percent of the Federal Poverty Level), and self-reported health status. Insurance coverage's incorporated in the model include Medicaid, Medicare, Individual Insured, Small Group Insured, Large Group Insured, Self-Funded, Employer Part-Time, Employer Retiree, and Uninsured. For each type of insurance coverage, enrollment is estimated by percent of Federal Poverty Level, Age, and Gender. Additionally, morbidity assumptions for both the baseline period and projection period are estimated.

The model uses the latest data available from multiple public and proprietary sources in order to understand the current market population by insurance coverage, age, gender, percent of Federal Poverty Level (FPL), health status, and Metropolitan Statistical Area (MSA).

The data utilized by the Model is comprised of public data sources outlined below.

- Current Population Survey (CPS) data – This data, which is updated monthly, provides us with demographic information by insurance coverage, age, FPL, and health status. In order to obtain a credible sample size, CPS data from 2009 through 2011 is summarized. In situations where CPS sample size credibility is a concern, state data is blended with the corresponding HHS regional data to further enhance credibility in modeling results.
- American Community Survey (ACS) data – Because of a larger sample size, ACS data is used in order to provide more accurate enrollment counts by insurance coverage, age, gender, and FPL. This population count data is merged with the CPS data by health status in order to obtain a detailed estimate of the current population.
- MLR data – Publically available 2011 Medical Loss Ratio Reporting Form data (MLR) is used in order to determine the current number of covered lives by insurance segment (Individual, Small Group, Large Group). This data also provides insight on claims and premiums per member per month (PMPM) for these insurance segments.

In addition to the data sources described above, the ***Milliman Health Cost Guidelines™*** (HCG) and ***Milliman Medical Underwriting Guidelines™*** (MUG) are utilized. These sources provide insight into items such as relative claims cost by age, gender, and health status. Pairing the HCG and MUG data with the publicly available data sources enables the Model to produce age/gender and morbidity estimates for the population.

Each of the data sources outlined plays a specific role in understanding the current population. The methodology implemented within the model is outlined below.

- The CPS data is utilized to estimate the percent of the population in Excellent, Very Good, Good, and Fair/Poor Health Status.
- ACS data is utilized to estimate the population breakdown by insurance coverage, age, gender, FPL, health status, and MSA.
- MLR data is used to understand the size of the insured markets (Individual, Small Group, Large Group), along with estimating current market claims PMPM.

The proportion of the population that will purchase coverage on the RIHBE is then estimated (i.e., "take-up"). These take-up rate assumptions are primarily driven by a member's current insurance status (i.e., insured or uninsured) and the federal subsidy available (if any) if the member enrolls in a plan on the RIHBE.

We then applied employer-sponsored insurance transition rates and individual/uninsured RIHBE take-up rates to estimate the population counts in each market (stratified by income-to-poverty ratio, health status, and family size). The result is a 2014 population projection by cohort (i.e., age, gender, income, and exchange status).

B. Step 2: Project NHPRI Enrollment by Market and Exchange Status

NHPRI's expected 2014 Individual enrollment was projected based on our estimate of the statewide population and market share estimates provided by NHPRI. As NHPRI will only be offering products on the RIHBE, it is assumed that no off exchange enrollment will exist. We estimated the members that would select each of NHPRI's benefit plans based on the plans for which they would qualify (given their age and income level). We also assumed that all 2014 members are enrolled for the entire year.

C. Step 3: Project Statewide Risk Scores For Use in the Risk Adjustment Transfer Payment

For the purpose of estimating NHPRI's risk adjustment transfer payment, the population projection model outlined in Step 1 was utilized to project statewide risk scores. This was completed by inferring the health status of the projected insured population by cohort using the self-reported health status field in the CPS data. Relative health status factors for each self-reported health status category, developed based on data available within the MUGs, were inferred based on the proportion of members within each self-reported health status category. These inferred relative health status factors were combined with age/gender claim cost factors from the HCGs to produce final statewide average risk scores for each population cohort.

D. Step 4: Project NHPRI's Risk Score For Use in the Risk Adjustment Transfer Payment

We assumed that NHPRI's risk scores for a given age, gender, and FPL cohort were comparable to the statewide average risk scores for the same cohort. This assumption relies on there being similar Selection and Coding Intensity between NHPRI and the statewide average. Selection refers to the health status difference between a given carrier and the overall market. Coding Intensity refers to a differing frequency and accuracy with which diagnosis codes are captured in claims data impacting the calculated risk score of the population. We did not model the impact of selection between the metal plans because carriers are not permitted to rate for selection.

E. Step 5: Estimate 2014 Statewide Average Claims for the Risk Adjustment Transfer Payments

To estimate the statewide premium in NHPRI's risk adjustment transfer payment, the statewide claim costs were estimated using 2011 Medical Loss Ratio Reporting Form (MLR) data. Blue Cross & Blue Shield of Rhode Island is the predominant carrier in Rhode Island, and as a result, was the focus of this portion of the analysis.

Statewide claim cost PMPM was calculated by adjusting for:

- Trend from 2011 to 2014,
- The pharmacy and device taxes,
- Health status changes due to uninsured individuals entering the insured market,
- Uninsured pent-up demand for medical services,

- Assumed "richness" of the plans and the resulting utilization patterns resulting from a given benefit design level, and
- Additional induced utilization for those enrolling in alternate Silver plans (i.e., those with cost sharing reductions).

When trending figures within the analysis, a consistent annual trend assumption of 5.8% was used for each year.

F. Step 6: Project NHPRI's 2014 Claim Costs

Since no experience is currently available for NHPRI, 2014 claim costs were developed using the ***Milliman Managed Care Rating Model*** (MCRM) and the ***Milliman Prescription Drug Rating Model*** (RXRM). These models were calibrated to reflect cost and utilization levels appropriate for NHPRI's assumed provider contracting arrangements and enrollment characteristics.

Specific considerations included:

- Reflecting NHPRI's assumed 2014 provider reimbursement rates,
- Reflecting NHPRI's assumed utilization rates,
- Adjusting the degree of healthcare management,
- Reflecting NHPRI's plan designs, and
- Reflecting results produced through the population modeling work, including assumptions for morbidity and pent-up demand.

These models were used in order to estimate utilization per 1,000 and average cost per service for the purpose of developing NHPRI's credibility manual. Finally, we projected claim costs PMPM for every combination of age, gender, metal plan, income level, and exchange status.

G. Step 7: Add Administrative Expenses

Administrative expenses were added to NHPRI's claim costs, including:

- General Administrative Expenses,
- Commercial Reinsurance Premium Net of Recoveries,
- Quality Improvement/Information Technology,
- Premium Tax,
- Comparative Effectiveness Research,
- Reinsurance Operating Fee,
- Risk Adjustment Admin Fee, and
- Contribution to Surplus.

Additional details related to administrative expenses can be found in Section XI, Non-Benefit Expenses and Profit & Risk.

H. Step 8: Add Estimated Federal Transitional Reinsurance Expenses

Additional costs or savings due to the Federal transitional reinsurance program were estimated. Differences exist between the markets since only the individual market is eligible for transitional reinsurance. It was assumed that NHPRI would pay $5.25 PMPM in reinsurance contributions. Reinsurance recoveries were estimated under the assumption that the individual market will receive 80% of all individual members' PMPY incurred claims between $60,000 and $250,000.

We estimated this value by calibrating claim probability distributions (CPDs) within the MCRM for each of NHPRI's individual benefit plans estimated PMPM claims.

Additional details related to Federal Transitional Reinsurance can be found in Section X, Risk Adjusters and Reinsurance.

I. Step 9: Estimate NHPRI's Risk Adjustment Transfer Payment

NHPRI's risk adjustment transfer payment was estimated using the CMS formula, which includes the statewide average premium, induced demand factor, geographical cost factor, NHPRI's risk score by plan, the plan's actuarial value, and allowable rating factors. The key determinant of whether NHPRI receives or makes a transfer payment is how NHPRI's risk score (normalized across all carriers) compares to the product of the actuarial value and allowable rating factors (normalized across all carriers).

The statewide average premium was estimated by adding expenses to the statewide average claim costs (i.e., Steps 5 and 7). Next, NHPRI's risk scores were normalized from Step 4 to the statewide average risk score by removing the portion of NHPRIs' risk score that can be accounted for through age rating factors, leaving an "uncompensated risk" factor. We then multiplied the "uncompensated risk" factor by the state average premium PMPM to estimate the net risk adjustment PMPM received or payable by NHPRI.

Additional details related to Risk Adjustment can be found in Section X, Risk Adjusters and Reinsurance.

J. Step 10: Calculate Composite Required Premium

The composite required premium was calculated by summing expected claims, administrative expenses, the net impact of federal reinsurance, and the net impact of state risk adjustment. An additional load was added to account for family policies with more than three members under the age of 21. Lastly, it was verified that no expected minimum loss ratio rebates or risk corridor payments we estimated to result from the established premium rates.

K. Step 11: Calculate Premiums by Rate Cell

The composite required premium was divided by the composite of all allowable rating factors across NHPRI's projected block of business by rating cell to determine a base rate. This base rate, in combination with the allowable rating factors, will result in the premium rates charged to enrollees in 2014.

Age and plan design are the only allowable rating factors for each cohort in Rhode Island. We developed NHPRI's rating factors to meet the regulatory requirements below:

- Age factors as specified by law, and
- Plan factors based on the plan's actuarial value, cost sharing utilization, network, and cost of administration.

VIII. CREDIBILITY OF EXPERIENCE

Since no experience data is available, a credibility assumption of 0% was applied. The manual rates developed through the steps outlined under Section VII are the sole basis for the premium rates proposed in this memorandum.

IX. PAID TO ALLOWED RATIO

The paid to allowed ratio provided in Worksheet 1, Section III of the Unified Rate Review Template (URRT) and in "II Data Collection" of the 2013 Rate Review Process OHIC Template was developed using the MCRM and RXRM models calibrated for the purpose of developing NHPRI's manual rates. These models were used to develop both paid and allowed claims on a per member per month (PMPM) basis for every combination of age, gender, metal plan, income level, and exchange status. The resulting paid and allowed claims PMPM were weighted based on NHPRI's membership projections in order to arrive at an estimated paid to allowed ratio. While utilization differences were considered for the CSR eligible population, the benefits reflected within the paid claim PMPM estimates reflected a silver level of coverage for individuals assumed enrolled in CSR plans.

X. RISK ADJUSTERS AND REINSURANCE

The processes used to estimate risk adjustment and reinsurance were completed in Steps 9 and 8 of the premium development process respectively.

A. Risk Adjustment Transfer Payment Estimate

NHPRI's risk adjustment transfer payment was estimated using the CMS formula, which includes the statewide average premium, induced demand factor, geographical cost factor, NHPRI's risk score by plan, the plan's actuarial value, and allowable rating factors. The key determinant of whether NHPRI receives or makes a transfer payment is how NHPRI's risk score (normalized across all carriers) compares to the product of the actuarial value and allowable rating factors (normalized across all carriers).

The statewide average premium was estimated by adding expenses to the statewide average claim costs produced in the premium development process (Steps 5 and 7). Next, NHPRI's risk scores (from Step 4 of the premium development process) were normalized to the statewide average risk score and the portion of NHPRIs' risk score that can be accounted for through age rating factors was removed; leaving an "uncompensated risk" factor. We then multiplied the "uncompensated risk" factor by the state average premium PMPM to estimate the net risk adjustment PMPM received or payable by NHPRI.

While products will be made available to all income levels, NHPRI's target population in the individual market includes lower income individuals eligible to receive subsidies. It is assumed that lower income individuals have a higher risk compared to higher income individuals. With this in mind, we are estimating NHPRI to receive risk adjustment payments. The estimated PMPM risk adjustment received by NHPRI was aggregated in order to determine the appropriate impact as a percent of premium. The process resulted in an estimated risk adjustment premium impact of approximately -2% (-$8.77 PMPM). Premium rates developed for NHPRI were thus reduced by this percentage in order to appropriately reflect the estimated risk adjustment transfers.

B. Federal Transitional Reinsurance Estimate

Additional costs or savings due to the Federal transitional reinsurance program were estimated. Differences exist between the markets since only the individual market is eligible for transitional reinsurance. It was assumed that NHPRI would pay $5.25 PMPM in reinsurance contributions. Reinsurance recoveries were estimated under the assumption that the individual market will

receive 80% of all individual members' PMPY incurred claims between $60,000 and $250,000. We estimated this value by calibrating claim probability distributions (CPDs) within the MCRM for each of NHPRI's individual benefit plans estimated PMPM claims.

This calculation was performed separately for each combination of age, gender, metal plan, income level, and exchange status. In order to appropriately allocate estimated reinsurance payments, the PMPM results were aggregated to estimate the impact as a percent of premium. Before reflecting reinsurance contributions, Federal transitional reinsurance resulted in an approximately 10% reduction to premium (-$40.08 PMPM). This figure drops to approximately 9% (-$34.83 PMPM) after reflecting the contributions NHPRI is estimated to pay.

XI. NON-BENEFIT EXPENSES AND PROFIT & RISK

The proposed rates reflect an administrative load of approximately 20% including General Administrative Expenses, Contribution to Surplus, Taxes and Fees. This load was developed through the use of assumptions provided to Milliman from NHPRI.

A. Administrative Expense Load

The table below outlines the Administrative Expenses that are reflected in the proposed premium rates. These expenses were developed using assumptions provided to Milliman from NHPRI. All categories are demonstrated as both a PMPM and percent of premium. However, please note that some items were developed and applied on a different basis. In these situations, items have been converted to PMPM equivalents or Percent of Premium equivalents as needed for illustrative purposes.

Table 1: Administrative Expenses

Description	PMPM Equivalent	Percent of Premium
General Administrative Expense	$ 39.35	10.0%
Commercial Reinsurance Net of Recoveries	$ 1.75	0.4%
Quality Improvement	$ 7.29	1.9%
Additional Child Load	$ 3.55	0.9%

NHPRI will not be paying any broker commissions and, as such, administrative expenses associated with commissions are not reflected. The Additional Child Load is intended to reflect that rates for family policies cannot account for more than three members under the age of 21. A portion of this load will be reflected in claims experience in subsequent years (approximately 0.7%), while the remaining portion is intended to account for additional administrative expenses associated with these members.

B. Contribution to Surplus & Risk margin

The proposed rates reflect 3% of premium being allocated to Contribution to Surplus & Risk Margin. This load was applied evenly to all plans being offered by NHPRI.

C. Taxes and Fees

The table below outlines the Taxes and Fees that are included in the non-benefit expenses.

Table 2: Taxes and Fees

Description	PMPM Equivalent	Percent of Premium
Premium Tax	$ 7.86	2.00%
Comparative Effectiveness Research	$ 0.17	0.04%
Reinsurance Operating Fee	$ 0.11	0.03%
Risk Adjustment Admin Fee	$ 0.08	0.02%

It is currently understood that there will be no Exchange Operation Fees in Rhode Island for calendar year 2014. Additionally, it is assumed that NHPRI will not be assessed the Health Insurer Tax provided that over 80% of premiums are received for Medicaid.

XII. PROJECTED LOSS RATIO

The projected loss ratio for NHPRI's Individual bock of business is approximately 86.8%. This loss ratio is calculated consistently with the Federally prescribed MLR methodology, and reflects the projected loss ratio prior to reflecting any applicable credibility adjustments. A credibility adjusted loss ratio is estimated at approximately 90.9% based on membership projections developed by Milliman with guidance from NHPRI.

XIII. INDEX RATE

No experience data was made available as NHPRI current does not offer plans in the commercial health insurance market. As such, an index rate for the experience period was not calculated.

For the projection period, the index rate was calculated using information produced during the premium rate development process. The index rate provided reflects the estimated total allowed claims divided by total projected member months. The estimate produced reflects the utilization level, demographics, etc. of NHPRI's assumed enrollment. There will be no non-essential health benefits included in NHPRI plans. Because of this, the index rate provided aligns with the projected allowed claims PMPM.

In order to arrive at each plan's rate level based on the projected index rate, adjustments for the following items are considered:

- Cost sharing structure of the plan,
- Assumed cost sharing utilization of the plan, and
- Administrative costs.

All plans offered have a consistent provider network, utilization management, and delivery system. Additionally, items such as risk adjustment and reinsurance are accounted for consistently on all plans. Also, as previously noted non-essential health benefits will not be offered. Assumptions for cost structure and utilization differences by plan are outlined within Section XV, AV Pricing Values.

XIV. AV METAL VALUES

In the Individual market, NHPRI intends to offer two plans along with their corresponding CSR and Indian Cost-Sharing permutations.

Specifically, plans to be offered include the following:

- One plan at the Gold metal level,
- One plan at the Silver metal level,
- Three CSR plans to correspond with the Silver offering,
- One Zero Cost-Sharing plan for Indian's under 300% of FPL, and
- Two Limited Cost-Sharing plans for Indians to correspond with the Gold and Silver plans.

The AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template were based on the Federal AV Calculator. No adjustments to plan cost sharing were needed in order to determine AV using the Federal AV Calculator. While the Federal AV Calculator does not contain an input for every potential variation in plan designs, it is assumed that the majority of variation between AVs is being captured by the plan characteristics available within the Federal AV Calculator. This assumption is consistent with documentation provided within the Actuarial Value Calculator Methodology document made available by the Department of Health and Human Services.

XV. AV PRICING VALUES

AV pricing values were developed based on the allowable rating factors for each cohort in Rhode Island. In order to be consistent with the OHIC rate review process, the premium of a plan covering 100% of allowed costs for a 21-year old assuming Silver Metal Level utilization was calculated as the fixed reference plan for basis of the AV Pricing Values. We developed NHPRI's rating factors to meet the regulatory requirements below:

- Age factors as specified by law, and
- Plan factors based on the plan's actuarial value, cost sharing utilization, network, and cost of administration.

There are no assumed network differences between the plans being offered by NHPRI. Also, administrative costs are assumed to be consistent for each offering. However, certain administrative costs are developed on a PMPM basis and thus when demonstrated as a percent of premium they may vary.

The MCRM model calibrated for the purpose of developing NHPRI's manual rates was utilized for developing NHPRI's AV Pricing Values. This MCRM model is based on data from the ***Milliman Health Cost Guidelines™*** (HCGs). The HCGs provide a flexible but consistent basis for the determination of claim costs for a wide variety of health benefit plans. These rating structures are used to anticipate future claim levels, evaluate past experience and establish interrelationships between different benefit levels.

The HCGs are developed as a result of Milliman's continuing research on health care costs. They were first developed in 1954 and have been updated and expanded annually since then. These guidelines are continually monitored as we use them in measuring the experience or evaluating the rates of our clients and as we compare them to other data sources.

The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research and judgment. An extensive amount of data is used in developing these guidelines, including published and unpublished data. In most instances, cost assumptions are based upon our evaluation of several data sources and, hence, are not specifically attributable to a single source. Since these guidelines are a proprietary document of Milliman, they are only available for release to specific clients that lease these guidelines and to Milliman consulting health actuaries.

We used the calibrated MCRM model to estimate the value of cost-sharing and relative utilization of services for each plan. Our pricing models assume the same demographic and risk characteristics for each plan priced, thereby excluding expected differences in the morbidity of members assumed to select the plan.

The table below includes AV Pricing Values for the two plans offered on the Individual market. Factors are shown separately for utilization and relative AV, the product of which produces the proposed AV Pricing Value.

Table 3: Cost Sharing Utilization Factor by Metal Level

Metal Level	Cost Sharing Utilization Factor	Relative AV Factor	AV Pricing Value
Gold	1.06	0.82	0.87
Silver	1.00	0.75	0.75

For individuals enrolled in the 87% or 94% CSR plans, it was assumed that utilization will be 12% higher consistent with CMS guidance. While products will be made available to all income levels, it is assumed that NHPRI's membership will largely consist of CSR eligible individuals. The impact associated with CSR utilization is being applied evenly across all plan designs and metal level offerings.

XVI. MEMBERSHIP PROJECTIONS

The membership projections were developed in conjunction with NHPRI. These projections reflect market share estimates assumed by NHPRI. Additionally, the projections reflect the total market size estimated in Step 1 of the premium development process.

The population projection modeling completed in the premium rate development process was used to determine the proportion of NHPRI membership that would be eligible for CSR plans. Membership by plan and subsidy level is outlined in the table below.

Table 4: Membership by Plan and Subsidy Level

Plan	Membership
Gold	202
Silver (94% CSR)	740
Silver (87% CSR)	3,150
Silver (73% CSR)	1,819
Silver (70%)	809
Total	**6,720**

XVII. TERMINATED PRODUCTS

Not applicable. No plans are being terminated as NHPRI currently does not offer products in the Individual market.

XVIII. PLAN TYPE

Not applicable. The plan types listed in Worksheet 2, Section I of the Part I Unified Rate Review Template appropriately describe NHPRI's plans.

XIX. WARNING ALERTS

The following differences between the plan-level projections in Worksheet 2 and the total projected amounts found in Worksheet 1 were noted.

Explanations regarding these differences are as follows:

- A warning is listed in cell A82 of Worksheet 2, Plan Product Info. This warning is the result of rounding differences between values listed within the workbook. Total Premium is appropriately aligning to the nearest dollar.
- A warning is listed in cell A99 of Worksheet 2, Plan Product Info. This warning appears to be due to the template checking total allowed claims before reinsurance and risk adjustment to a calculation that represents total allowed claims after these items.

XX. EFFECTIVE RATE REVIEW INFORMATION

The following section contains additional information and documentation pertaining to the 2013 Rate Review Process OHIC Template.

As previously indicated, experience data was not available for the purpose of developing premium rates for NHPRI's products. Because of this, some sections of the OHIC Template have been intentionally left blank. Additionally, methodologies utilized for rate development purposes are consistent with those described in prior sections of the document. This section is intended to capture documentation for information not included within the Part I Unified Rate Review Template.

A. Experience Data

- **Part 1. Historical Information**
  Since no experience data was available, Part 1 has not been completed.
- **Part 2. Prospective Information**
  Since no experience data was available, sections A and C have not been completed. Section B was completed using assumptions consistent with the premium rate development process outlined in Section VII of this memorandum. The Expected Pure Medical Cost Ratio was calculated as estimated total claims PMPM divided by projected total premium PMPM. This calculation is not intended to be consistent with the Federally prescribed MLR methodology. Administrative cost percentages are consistent with values shown in Section XI of this memorandum, yet are allocated to the prescribed categories.

B. Data Collection

Information contained in this section and corresponding documentation is consistent with values shown within the Part I Unified Rate Review Template; however, it contains two additional items.

- **Base EHB Rate for Projection Period**

This value was calculated by adjusting the Index Rate to reflect the premium of a plan covering 100% of allowed cost for a 21-year old enrollee assuming Silver Metal Level utilization. To accomplish this, composite age and cost sharing utilization factors were calculated.

A description of the methodology used to calculate cost sharing utilization factors is available within Section XV of this memorandum. Additional supporting calculations have been provided within the 2013 Rate Review OHIC Template.

- **Monthly Effective Date Projection Factor**

This section is not applicable for the Individual market.

Additionally, the information requested in rows 47 and 48 of this tab is not identical to the corresponding section of the Part 1 Unified Rate Review Template. The primary difference is that the Federal template requests 'Taxes & Fees' while the 2013 OHIC Template specifically requests 'Premium Tax'. To account for this variation, Taxes and Fees other than Premium Tax have been included in the 'Administrative Expense Load' field.

C. Plan Rates

All products are new for 2014; therefore, 2013 values have been left blank within this template. Metallic Tier Actuarial Value was calculated in an identical manner as outlined in Section XIV, AV Metal Values. AVs provided within this section align with values shown in Worksheet 2 of the Part I Unified Rate Review Template. Additionally, the Proposed Plan Relativity Factors are consistent with the values outlined in Section XV, AV Pricing Values. A description and supporting information for these values can be found within that portion of this memorandum.

Membership for 1/1/2014 was estimated using membership projections as outlined in XVI, Membership Projections. As outlined within the premium development process, publically available survey data was used for the purpose of understanding the current population. Projections were performed at the member level as data was not made available at the group and/or subscriber level in the available survey data. For this reason, columns R and S have not been completed.

The proposed base rate PMPM reflects the premium of a plan covering 100% of allowed claims for a 21-year old enrollee with utilization set at the Silver Metal Level. This figure aligns with the base EHB rate shown in the second tab of the template. Pediatric Dental benefits will not be offered. Each member's rate can be calculated as the product of the EHB Base Rate, the AV Pricing Value, and the appropriate Age Factor. Please note that AV Pricing Values were developed in a different manner, yet presented as a percentage of the EHB Base Rate for filing purposes.

D. Administrative Costs

As outlined in Section XI of this memorandum, administrative costs were developed through the use of assumptions provided to Milliman from NHPRI. Prior year administrative cost data is not available due to NHPRI currently not offering products in the commercial market. Administrative costs were broken down in to the applicable categories through the use of assumptions provided to Milliman from NHPRI.

It is currently understood that there will be no Exchange Operation Fees in Rhode Island for calendar year 2014. Additionally, it is assumed that NHPRI will not be assessed the Health Insurer Tax provided that over 80% of premiums are received for Medicaid.

Additional details related to administrative costs can be found in Section XI, Non-Benefit Expenses and Profit & Risk.

XXI. RELIANCE

In developing the premium rates in this actuarial memorandum, I relied on data and other information provided by NHPRI. I have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of the analysis may likewise be inaccurate or incomplete. I performed a limited review of the data used directly in the analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of my assignment.

XXII. ACTUARIAL CERTIFICATION

I, Jeremy D. Palmer, am a member of the American Academy of Actuaries and meet its qualification standards for actuaries issuing statements of actuarial opinion in the United States. I have been retained by Neighborhood Health Plan of Rhode Island (the "Company") to prepare this filing.

I am affiliated with Milliman, Inc. ("Milliman"), an independent actuarial consulting firm that is not affiliated with, nor a subsidiary, nor in any way owned or controlled by a health plan, health insurer, or a trade association of health plans or insurers.

I hereby certify that the projected index rate is, to the best of my knowledge and understanding:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)).
- Developed in compliance with the applicable Actuarial Standards of Practice.
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Neither excessive nor deficient.

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates. The allowable modifiers used to generate plan-level rates were:

- The actuarial value and cost-sharing design of the plan.
- The plan's provider network, delivery system characteristics, and utilization management practices.
- Administrative costs, excluding Exchange user fees.

I certify that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with relevant actuarial standards of practice.

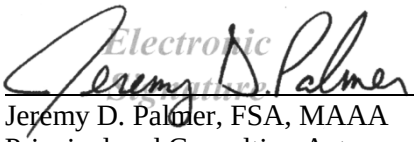
I certify that the benefits included within Neighborhood's plans are substantially equivalent to the Essential Health Benefits (EHBs) in the State of Rhode Island's benchmark plans. I certify that any benefit substitutions are:

- Actuarially equivalent to the benefits being replaced,
- Are made within only the same essential health benefit category,
- Are based on a standardized plan population,
- Are determined regardless of cost-sharing,

- Are not prescription drug benefits, and
- Are based on an analysis performed in accordance with generally accepted actuarial principles and methodologies.

I certify that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans except those specified in the certification. The AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template were based on the Federal AV Calculator. No adjustments to plan cost sharing were needed in order to determine AV using the Federal AV Calculator. While the Federal AV Calculator does not contain an input for every potential variation in plan designs, it is assumed that the majority of variation between AVs is being captured by the plan characteristics available within the Federal AV Calculator. This assumption is consistent with documentation provided within the Actuarial Value Calculator Methodology document made available by the Department of Health and Human Services.

The Part I Unified Rate Review Template and the 2013 Rate Review Process OHIC Template do not demonstrate the process used by Milliman to develop the rates. Rather, it represents information required by Federal and State regulations to be provided in support of the review of rate increases, for certification of qualified health plans that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.



Jeremy D. Palmer, FSA, MAAA
Principal and Consulting Actuary

April 30, 2013
Date

State: Rhode Island **Filing Company:** Neighborhood Health Plan of Rhode Island
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: Neighborhood - Individual Market Product
Project Name/Number: NHPRI Health Exchange 2014 - Individual Market/NHPRI Individual Market 2

Note To Filer

Created By:

Patrick Tigue on 04/22/2013 09:58 PM

Last Edited By:

Patrick Tigue

Submitted On:

04/22/2013 09:58 PM

Subject:

2013 Form and Rate Review Processes Outstanding Filing Materials Memo- NHPRI

Comments:

Please see the attached memo.

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

To: Art Greenwood, Policy and Planning Project Lead, Neighborhood Health Plan of Rhode Island and T. Clark Phillip, Jr., Chief Financial Officer, Neighborhood Health Plan of Rhode Island

CC: Herb Olson, Executive Counsel, State of Rhode Island Office of the Health Insurance Commissioner, Beth Ann Marootian, Director of Business Development, Neighborhood Health Plan of Rhode Island

From: Linda Johnson, Operations Director, State of Rhode Island Office of the Health Insurance Commissioner and Patrick M. Tigue, Principal Policy Associate, State of Rhode Island Office of the Health Insurance Commissioner

Subject: 2013 Form and Rate Review Processes Outstanding Filing Materials- Neighborhood Health Plan of Rhode Island

Date: April 22, 2013

Below please find a listing of 2013 form and rate review processes filing materials that you have yet to file in the proper manner or at all through the System for Electronic Rate and Form Filing (SERFF). These materials are divided into those that could have been filed on April 15, 2013, which are now due on May 1, 2013 and those that could not have been filed on April 15, 2013, which are now due on May 15, 2013. These materials are critical to implementation of the Affordable Care Act (ACA) and to the State of Rhode Island Office of the Health Insurance Commissioner's (OHIC) review of ACA-compliant forms and rates. The Commissioner has the authority to commence proceedings under State of Rhode Island General Laws § 42-14-16 in the case of a violation of an issuer's obligation to make a complete filing in a timely manner and in accordance with State of Rhode Island laws and regulations.

Outstanding Materials That Should Have Been Filed on April 15, 2013 (Now Due on May 1, 2013)

- **Individual Market:**
    - Subscriber Agreement documents (e.g., Certificate of Coverage, Evidence of Coverage, etc.) with a listing of covered benefits and cost sharing for each Subscriber Agreement filed. These must be filed using the SERFF Plan Management Platform according to the Rhode Island Plan Management Filing Instructions to include the binder format and the "Associate Schedule Item" tab for each plan identified by a Standard Component ID number.
    - Subscriber Agreements with a listing of covered benefits and cost sharing in the standard SERFF filing format placing these documents in the "Form Schedule" tab. Standard SERFF form filing must be according to the SERFF filing rules for Rhode Island and according to OHIC's Checklist for Individual and Small Group Plans. The standard SERFF filing documents must easily crosswalk and correspond to the SERFF Plan Management Platform filings.
    - Identification by the issuer of any and all changes to Subscriber Agreements previously submitted as part of the Preliminary Form Filing process by submitting a red-lined version and a clean version of the Subscriber Agreements. Also, the issuer must identify in the General Information Filing Description section of SERFF any Subscriber Agreement that was not previously filed as part of the Preliminary Form Filing process.
    - Readability Attestations to correspond to current filing documents and dates
    - PPACA Compliance Summary to correspond with current filing documents and dates

State of Rhode Island Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Building 69-1
Cranston, RI 02920-4407
(401) 462-9517
(401) 462-9645 (Fax)
www.ohic.ri.gov

- Revised 2013 OHIC Rate Review Process Template, incorporating the assumption of serving individuals above 250% of the federal poverty level (FPL)
- Actuarial Memorandum supporting the Revised 2013 OHIC Rate Review Process Template, incorporating the assumption of serving individuals above 250% FPL

- **Small Group Market:**
  - Subscriber Agreement documents (e.g., Certificate of Coverage, Evidence of Coverage, etc.) with a listing of covered benefits and cost sharing for each Subscriber Agreement filed. These must be filed using the SERFF Plan Management Platform according to the Rhode Island Plan Management Filing Instructions to include the binder format and the "Associate Schedule Item" tab for each plan identified by a Standard Component ID number.
  - Subscriber Agreements with a listing of covered benefits and cost sharing in the standard SERFF filing format placing these documents in the "Form Schedule" tab. Standard SERFF form filing must be according to the SERFF filing rules for Rhode Island and according to OHIC's Checklist for Individual and Small Group Plans. The standard SERFF filing documents must easily crosswalk and correspond to the SERFF Plan Management Platform filings.
  - Identification by the issuer of any and all changes to Subscriber Agreements previously submitted as part of the Preliminary Form Filing process by submitting a red-lined version and a clean version of the Subscriber Agreements. Also, the issuer must identify in the General Information Filing Description section of SERFF any Subscriber Agreement that was not previously filed as part of the Preliminary Form Filing process.
  - Readability Attestations to correspond to current filing documents and dates
  - PPACA Compliance Summary to correspond with current filing documents and dates
  - Revised 2013 OHIC Rate Review Process Template incorporating the assumption of serving individuals above 250% of the federal poverty level (FPL)
  - Actuarial Memorandum supporting the Revised 2013 OHIC Rate Review Process Template incorporating the assumption of serving individuals above 250% FPL

Outstanding Materials That Could Not Have Been Filed on April 15, 2013 (Now Due on May 15, 2013)

- **Individual Market:**
  - Administrative Template
  - Essential Community Providers Template
  - Network Template
  - Plans/Benefit Template
  - Prescription Drug Template
  - Rate Data Templates
  - Service Area Template

State of Rhode Island Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Building 69-1
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(401) 462-9517
(401) 462-9645 (Fax)
www.ohic.ri.gov

- **Small Group Market:**
  - Administrative Template
  - Essential Community Providers Template
  - Network Template
  - Plans/Benefit Template
  - Prescription Drug Template
  - Rate Data Templates
  - Service Area Template
  - Reconciliation of all other requests noted in the SERFF Preliminary Form Filing Note to Filer dated April 8, 2013 that has not been determined as Outstanding Materials now due on May 1, 2013

Should have any questions on how to proceed based on this memo, please do not hesitate to contact Linda Johnson at (401) 462-9642 or linda.johhnson@ohic.ri.gov for issues related to the form review process and Patrick Tigue at (401) 462-9639 or patrick.tigue@ohic.ri.gov for issues related to the rate review process. Thank you for your attention to this matter.

Note To Reviewer

Created By:

Arthur Greenwood on 04/17/2013 01:43 PM

Last Edited By:

Arthur Greenwood

Submitted On:

04/17/2013 01:49 PM

Subject:

Response to Timeline Request

Comments:

In response to reviewers request, NHPRI is targeting May 10th to have subscriber documents completed. We have established a work team and secured consulting resources to insure meeting this deliverable. As discussed in our April 11th meeting, NHPRI will provide ongoing updates regarding our progress and clarifying any issues and concerns to insure the May 11th document meets required regulatory guidance.

Sincerely,
Art Greenwood

Note To Filer

Created By:

Linda Johnson on 04/16/2013 11:14 AM

Last Edited By:

Linda Johnson

Submitted On:

04/16/2013 11:14 AM

Subject:

Timeline Request

Comments:

Art,

Per our preliminary review notes to filer and subsequent conversations, what is them NHPRI timeline for responding with changes to the form filings within this submission?

Linda

State: Rhode Island **Filing Company:** Neighborhood Health Plan of Rhode Island
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: Neighborhood - Individual Market Product
Project Name/Number: NHPRI Health Exchange 2014 - Individual Market/NHPRI Individual Market 2

Post Submission Update Request Submitted On 05/15/2013

Status: Submitted

Created By: Arthur Greenwood

General Information:

Field Name	Requested Change	Prior Value
Implementation Date Requested	01/01/2014	On Approval

Company Rate Information:

Company Name:Neighborhood Health Plan of Rhode Island

Field Name	Requested Change	Prior Value
Written Premium for this Program	$26480701	$0

SERFF Tracking #:	*NHRI-128972321*	***State Tracking #:***		***Company Tracking #:***	*NHPRI - INDIVIDUAL MARKET - 2*

State:	*Rhode Island*	***Filing Company:***	*Neighborhood Health Plan of Rhode Island*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*Neighborhood - Individual Market Product*		
Project Name/Number:	*NHPRI Health Exchange 2014 - Individual Market/NHPRI Individual Market 2*		

Form Schedule

Lead Form Number: NHPRI - Form 1

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Certificate of Coverages - Individual Market	NHPRI Individual - 1	CER	Initial		11.400	05-13 NHPRI CoC Individual (submission copy).pdf
2		Benefit Summaries	NHPRI Individual - 2	OTH	Initial		11.400	Benefit Summary - Individual Market - Silver Plan - v2 0.pdf, Benefit Summary - Individual Market - Gold Plan - v2 0.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

Certificate of Coverage

Neighborhood Health Plan of Rhode Island

INDIV (05-13)

WELCOME

Welcome to Neighborhood Health Plan of Rhode Island (Neighborhood). Below are a legal notice, some helpful tips, and phone numbers about your plan.

NOTICE

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

Words in *italics* (like *member* and *covered services*) have specific meanings in this Booklet. You can find these meanings listed in Chapter 10 at the end of this Booklet.This contract is solely between you and Neighborhood Health Plan of Rhode Island. Neighborhood Health Plan of Rhode Island is a Rhode Island non-profit, tax-exempt corporation formed by, and continues to be controlled by, Rhode Island's community health centers.

James A. Hooley,

Chief Executive Officer

PLEASE READ AND SAVE THIS DOCUMENT

This book is your *certificate of coverage* with Neighborhood Health Plan of Rhode Island (Neighborhood) and explains the benefits specific to your plan.

This booklet gives you the details about your health care *coverage* from January 1 – December 31, 2014. It explains how to get coverage for the health care services you need.

This is an important legal document. Please keep it in a safe place.

HELPFUL HINTS

- Read all information provided, Become familiar with services excluded from *coverage* (See Chapter 4, Section 4 – Benefits not *covered* by the plan.)

- In Chapter 10 – Glossary, there is a list of definitions of words used throughout this agreement. It is very helpful to become familiar with these words and their definitions. Words that are in *italics* have definitions in Chapter 10 at the end of this agreement.

- Member identification cards (Member ID) are provided to all Members. The Member ID card must be shown when obtaining health care services. Your Member ID card should be kept in a safe location, just like money, credit cards or other important documents. Neighborhood should be notified immediately if your Member ID card is lost or stolen.

- Our list of *network provider*s changes from time to time. You may want to call our *Member Services* Department in advance to make sure that a *provider* is a *network provider*.

- You are encouraged to become involved in your health care treatment by asking *provider*s about all treatment plans available and their costs. You also are encouraged to take advantage of the preventive health services offered under this agreement to help you stay healthy and find problems before they become serious.

IMPORTANT TELEPHONE NUMBERS, ADDRESSES, AND WEBSITES

Emergency care

For routine care, always call your *Primary Care Provider* (*PCP*). Do this before seeking care anywhere else. If you have an urgent medical need and cannot reach your *PCP* or your *PCP*'s covering *provider*, seek care at the nearest emergency room.

Important Note: If needed, call 911 for emergency medical assistance. If 911 services are not available in your area, call the local number for *emergency* medical services.

***Member Services* department**

Hours of Operation: Monday through Friday 8:30 a.m. – 5:00 p.m.

Call our Member Services Department at **855-321-XCHG (855-321-9244)** for general questions, assistance in selecting a Primary Care Physician (*PCP*), benefit questions, and information regarding eligibility for enrollment and billing.

Services for hearing impaired Members

Telecommunications Device for the Deaf – (Voice TDD) **401-459-6690**.

Mental health services

You may need information regarding mental health professionals in your area. If so, please call the Mental Health Department at 1-800-215-0058.

Our Website – provides additional information about Neighborhood Health Plan of Rhode Island as well as resources specific to your plan, such as formulary, *provider* directory and benefit plan descriptions. Please see Neighborhood Health Plan of Rhode Island's web site at **www.nhpri.org**

Grievance and Appeals unit

If you need to call us about a concern or *appeal*, please call *Member Services* at **855-321-XCHG (855-321-9244)** or, to submit an *appeal* or *complaint* in writing, please send your letter to:

Neighborhood Health Plan of Rhode Island
Attn: Grievance and Appeals Unit
299 Promenade Street
Providence, RI 02908

Translator Services

Our plan has people and free language interpreter services available to answer questions from non-English speaking Members. For information, please call our *Member Services* Department.

Preauthorization

Neighborhood only covers a service listed in this *certificate of coverage* if we or our designee determine that the care is *medically necessary*. *Preauthorization* is required for certain *covered services*. Services for which *preauthorization* is required are marked with an asterisk (*) in the Summary of Medical Benefits.

- **Medical/Surgical -** call our *Member Services* Department 855-321-XCHG (855-321-9244.
- **Mental Health and Chemical Dependency -** call 1-800-215-0058 before having care. Lines are open 24 hours a day, 7 days per week.

Your *network provider* is responsible for obtaining *preauthorization* for in-network *covered services*. If you would like to use a non-*network* provider for non-*emergency* services, and have us *cover* those services, you must request and obtain *preauthorization* from us first. Please call *Member Services* at 1-800-459-6019. Neighborhood's Medical Management Department will review your request for services.

2014 Certificate of Coverage

Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. You will find a detailed list of topics at the beginning of each chapter.

Benefit Overview

This table provides basic information about your benefits under this plan. See *Benefit Limits(defined in Chapter 10)* and Chapter 4 for detailed explanations of *Covered Services*. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

MEDICAL DEDUCTIBLE

The *Deductible* is the amount you and the enrolled *Members* of your family (if applicable) must pay each year for certain *Covered Services* before payments are made under this certificate of coverage.
Individual Medical *Deductible*..... $250-$3,000 per *Contract Year*
Family Medical *Deductible* ..... $500-$6,000 per *Contract Year*

This Family Medical *Deductible* applies for all enrolled *Members* of a family. All amounts any enrolled *Members* in a family pay toward their Individual *Deductibles* are applied toward the Family *Deductible*. The Family Medical *Deductible* is satisfied in a *Contract Year* when:

•one enrolled *Member* in family meets his or her $250-$3,000 Individual *Deductible*; **and**
•one or more additional enrolled *Members* in that family have paid toward their Individual Medical *Deductibles* a collective amount equal to the remaining balance of the family deductible in any combination. Once the Family Medical *Deductible* has been met during a *Contract Year*, all enrolled *Members* in a family will thereafter have satisfied their Individual *Deductibles* for the remainder of that *Contract Year.*

• The following are not subject to the Medical *Deductible*:
•*Emergency* care;
• Office visits for preventive care; office visits* for family planning; office visits to diagnose and treat illness or injury; mental health and substance abuse services; routine ob/gyn exam; routine eye exam; other vision care from an optometrist; *Outpatient* maternity care (pre-natal and post-partum)**; pediatric dental care; spinal manipulation; chiropractic medicine; nutritional counseling; and health education.
*including diagnostic tests associated with preventive health care, as described in Chapter 4.
**This does not include diagnostic tests such as ultrasounds.
•routine cytological exams (Pap Smears);
•early intervention services for a *Dependent Child;*
•preventive immunizations;
•routine mammograms;
•prostate and colorectal exams;
Any amounts you pay for prescription drugs. A separate *Deductible* applies to your prescription drug coverage. For more information, see "Prescription Drug Benefit" in Chapter 4.
•Any amount you pay for services, supplies, or medications that are not *Covered Services*.
• Once you meet your *Deductible* in a *Contract Year* for *Covered Services*, you pay only the following:
•Office visit *Copayment* for *Covered Services* not subject to the *Deductible*.
•Copayments for Emergency room; Inpatient Services*;* Day Surgery*;*
- ConinsuranceCopayments for Emergency room; Inpatient Services*;* Day Surgery*;*

Benefit Overview (continued)

PHARMACY *DEDUCTIBLE*

The Pharmacy *Deductible* is the amount you and the enrolled *Members* of your family (if applicable) must pay each year for certain *Covered Pharmacy Services* before payments are made under this certificate of c*overage*.

Individual Pharmacy *Deductible*..... $10-$250 per *Contract Year*
Family Pharmacy *Deductible* .....$20-$500 per *Contract Year*

This Family Pharmacy *Deductible* applies for all enrolled *Members* of a family. All amounts any enrolled *Members* in a family pay toward their Individual *Deductibles* are applied toward the Family Pharmacy *Deductible*. The Family *Deductible* is satisfied in a *Contract Year* when:

•one enrolled *Member* in family meets his or her $10-$250 Individual *Deductible*; **and**
•one or more additional enrolled *Members* in that family have paid toward their Individual *Deductibles* a collective amount equal to the remaining balance of the family deductible in any combination.

Once the Family *Deductible* has been met during a *Contract Year*, all enrolled *Members* in a family will thereafter have satisfied their Individual *Deductibles* for the remainder of that *Contract Year*.

Benefit Overview

COINSURANCE

Except as described in the "Benefit Overview" table below, the *Member* pays [0-30%] after the deductible is satisfied of the *Reasonable Charge* for certain *Covered Services*. The *Member* is also responsible for any charges in excess of the *Reasonable Charge*.

COPAYMENTS

• ***Emergency* Care:**
• Emergency room.....$25 - $200 *Copayment* per visit
• In *Provider's* office .....$5 - $50 *Copayment* per visit for care received from a Neighborhood provider.

Notes:

• An Emergency Room *Copayment* may apply if you register in an Emergency room but leave that facility without receiving care.
• A *Day Surgery Copayment* may apply if *Day Surgery* services are received.
• Urgent Care .. $5-$50 *Copayment* varies depending on type of *Provider* (*PCP* or Specialist) and location in which service is rendered (for example, *Emergency Room,* urgent care center, or physician's office).per visit

•Other *Covered Services*:

• Office Visit.....$5 -$50 - *Copayment* per visit for office visits.

Note: This *Copayment* applies to covered *Outpatient* care provided by your *PCP*, amental health/substance abuse *Provider*, or an obstetrician/ gynecologist ("Ob/Gyn"),as well as for *Outpatient* - physical, occupational, or speech therapy services, spinal manipulation, chiropractic medicine; acupuncture; early intervention services for a *dependent child*, cardiac rehabilitation services, and routine eye care.

Note: Certain *Outpatient* services may be listed as "covered in full" in the table below. If so, you may be charged the *Deductible* (if applicable) and an Office Visit *Copayment* when these services are provided

Benefit Overview (continued)

along with an office visit. In addition, please note that in accordance with the Patient Protection and Affordable Care Act (PPACA), certain services are not subject to a *Cost Sharing Amount* . Please see the following Benefit Overview chart for more information.

Benefit Overview, continued

MEDICAL OUT-OF-POCKET MAXIMUM

The Medical *Out-of-Pocket Maximum* is limited to the maximum dollar amount as defined each year by the Internal Revenue Service. For more information*,* see the definition of "*Out-of-Pocket Maximum"* in Appendix A.

The amount of the Medical *Out-of-Pocket Maximum* for you and the enrolled members of your family (if applicable) each c*ontract year* is:

Family Size Medical*Out-of-Pocket Maximum Amount*

- One Member..... $750- $5,000 per person.
- Two Members or more.....$1,500- $10,000 per family.

***Medical Out-of-Pocket Maximum* (Individual)**

This certificate of coverage has an individual Medical *Out-of-Pocket Maximum* of $750-$5,000 per *Member* per *Contract Year* for all *Covered Services.* Only *Copayments* , Deductibles and *Coinsurance* counts toward the Medical *Out-of-Pocket Maximum.* For more information , see the definition of *"Out-of-Pocket Maximum*" in Appendix A.

Medical *Out-of-Pocket Maximum* - (Family*)*

The Family Medical *Out-of-Pocket Maximum* is satisfied in *Contract Year* when enrolled *Members* in a family each meet their $750-$5,000 Individual Medical *Out-of-Pocket Maximum*. The Family Medical *Out-of-Pocket Maximum* is satisfied in a *Contract Year* when:

- one enrolled *Member* in family meets his or her $750-$5,000 Individual *Out-of-Pocket Maximum*; **and**
- one or more additional enrolled *Members* in that family have paid toward their Individual Medical *Out-of-Pocket Maximum* a collective amount equal to the remaining balance of the Family Medical *Out-of-Pocket Maximum.*

All amounts any enrolled *Members* in a family pay toward their Individual *Out-of-Pocket Maximums* are applied toward the $1,500-$10,000 Family Medical *Out-of-Pocket Maximum*. Once the Family *Out-of-Pocket Maximum* has been met during a *Contract Year*, all enrolled *Members* in a family will thereafter have satisfied their Individual Medical *Out-of-Pocket Maximums* for the remainder of that *Contract Year.*

Pharmacy *OUT-OF-POCKET MAXIMUM*

This certificate of coverage has an individual Pharmacy *Out-of-Pocket Maximum* of $100-$1,000 per *Member* per *Contract Year* for all *Covered Services.* Only *Copayments* , Deductibles and *Coinsurance* counts toward the Pharmacy *Out-of-Pocket Maximum.* For more information , see the definition of *"Out-of-Pocket Maximum*" in Appendix A.

The amount of the Pharmacy *Out-of-Pocket Maximum* for you and the enrolled members of your family (if applicable) each contract year is:

Benefit Overview (continued)

Family Size Pharmacy*Out-of-Pocket Maximum Amount*

• One Member..... $100- $1,000 per person.
• Two Members or more.....$200- $2,000 per family.

Pharmacy Out-of-Pocket Maximum **(Individual)**
The amount of the Pharmacy *Out-of-Pocket Maximum* for you and the enrolled members of your family (if applicable) each c*ontract year* is:
Family Size Pharmacy*Out-of-Pocket Maximum Amount*
• One Member..... $100- $1,000 per person.
• Two Members or more.....$200- $2,000 per family.

Pharmacy *Out-of-Pocket Maximum* - (Family*)*

The Family Pharmacy *Out-of-Pocket Maximum* is satisfied in *Contract Year* when enrolled *Members* in a family each meet their $100-$1,000 Individual Pharmacy *Out-of-Pocket Maximum*. The Family Pharmacy *Out-of-Pocket Maximum* is satisfied in a *Contract Year* when:
• one enrolled *Member* in family meets his or her $200-$2,000 Individual *Out-of-Pocket Maximum*; **and**
• one or more additional enrolled *Members* in that family have paid toward their Individual Pharmacy *Out-of-Pocket Maximum* a collective amount equal to the remaining balance of the Family Pharmacy *Out-of-Pocket Maximum.*

All amounts any enrolled *Members* in a family pay toward their Individual *Out-of-Pocket Maximums* are applied toward the $200-$2,000 Family Pharmacy *Out-of-Pocket Maximum*. Once the Family *Out-of-Pocket Maximum* has been met during a *Contract Year*, all enrolled *Members* in a family will thereafter have satisfied their Individual Pharmacy *Out-of-Pocket Maximums* for the remainder of that *Contract Year.*

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	Your Cost	Page
Emergency Care		
Treatment in an Emergency Room	*Copayment* per visit applies. (Waived if admitted as an *Inpatient* or for *Day Surgery*) **Note:** *Observation* services will not take an *Emergency* room *Copayment*.]	38
Treatment in a *Provider's* office	Care from a Neighborhood provider *Copayment* per visit applies	38
A *Member* should call *Neighborhood Health Plan* within 48 hours after *Emergency* Care is received. If you are admitted as an *Inpatient*, we recommend that you or someone acting for you call your *PCP* or *Neighborhood Health Plan* within 48 hours. A *Day Surgery Copayment* may apply if *Day Surgery* services are received.		
***Outpatient* Care**		
Allergy Testing **(PA)**	Deductible and coinsurance apply; no copayments apply .	38
Cardiac rehabilitation **(PA) (BL)**	Deductible and coinsurance apply; no copayments apply .	38
Chemotherapy	*Deductible* and c*oinsurance apply*.	38
Chiropractic **(BL), (PA)**	*Deductible* and c*oinsurance apply*.	38
Contraceptive Services	*Deductible* and c*oinsurance apply*.	39
Diabetes Services and Supplies **(PA)**	Diabetic test strips: *Deductible* and c*oinsurance apply*. Diabetes self-management education: *Deductible* and c*oinsurance apply*. Diabetes supplies covered as *Durable Pharmacy Equipment*: *Deductible* applies Diabetes supplies covered as pharmacy supplies: *Deductible* applies For information about your cost for diabetes supplies covered as prescription medication, see "Prescription Drug Benefit" in Chapter 4.	39

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Benefit Overview, continued
Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	**Your Cost**	**Page**
***Outpatient* Care, continued**		
Diagnostic Imaging **(PA)**	**Office Visit**: *Deductible* and c*oinsurance apply*.. ***Day Surgery**; Deductible* and c*oinsurance apply*. *Surgery* admission to a *Hospital* *This *Copayment* also applies for *Covered Day Surgery* services at a free- standing surgical center. (subject to *Inpatient* and *Day Surgery Copayment* Maximum)	40
Early Intervention Services **(PA), (BL)**	Deductible and coinsurance apply; no copayments apply .	41
Hemodialysis services	Deductible and coinsurance apply; no copayments apply .	41
Human leukocyte antigen testing or histocompatibility locus antigen testing **(PA)(BL)**	Deductible and coinsurance apply; no copayments apply .	41
Immunizations	*No deductible, coinsurance or* c*opayment apply*.	41
Infertility services **(PA), (BL)**	Deductible and coinsurance apply; no copayments apply .	42
Laboratory tests **(PA)**	Deductible and coinsurance apply; no copayments apply .	42

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Benefit Overview, continued
Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	**Your Cost**	**Page**
***Outpatient* Care, continued**		
Lead screenings	Deductible and coinsurance apply; no copayments apply .	43
Lyme disease	Deductible and coinsurance apply; no copayments apply .	43
Nutritional counseling **(PA)**	Deductible and coinsurance apply; no copayments apply .	43
Oral health services **(PA)**	Deductible and coinsurance apply; no copayments apply .	43
Outpatient free standing ambulatory surgi-center	Deductible and coinsurance apply; no copayments apply .	44
Outpatient surgery in a physicians office **(PA)**	Deductible and coinsurance apply; no copayments apply .	44
Podiatric services	*Copayment only applies*.	44
Preventive care	*No deductible, coinsurance or* co*payment apply*	44

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Benefit Overview, continued
Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	**Your Cost**	**Page**
Hearing examinations and screenings	Deductible and coinsurance apply; no copayments apply .	45
Prevention and early detection services **(BL)**	*No deductible, coinsurance or* co*payment apply*	45
Radiation Therapy	Deductible and coinsurance apply; no copayments apply	46
Respiratory therapy or pulmonary rehabilitation services **(PA)**	No deductible; copayment per visit applies.	46
Short term speech, physical and occupational therapy **(PA)**	No deductible; copayment per visit applies.	46
Smoking cessation counseling sessions	No deductible; copayment per visit applies.	46
Vision care **(PA), (BL)**	No deductible; copayment per visit applies	47

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Benefit Overview, continued
Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	**Your Cost**	**Page**
Inpatient care		
Hospital services **(PA)**	Deductible and coinsurance apply; no copayments apply	50
Reconstructive surgery and procedures and mastectomy surgeries **(PA)**	Deductible and coinsurance apply; no copayments apply	50
Skilled care in a nursing facility **(PA)**	Deductible and coinsurance apply; no copayments apply	51
Solid organ and hematopietic stem cell transplants **(PA)**	Deductible and coinsurance apply; no copayments apply	51
Maternity Care		
Maternity care – Outpatient **(PA)**	Deductible and coinsurance apply; no copayments apply	52
Maternity care – Inpatient **(PA)**	Deductible and coinsurance apply; no copayments apply	52

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Benefit Overview, continued
Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	Your Cost	Page
Behavioral Health Services for Mental Health Care		
Outpatient mental health care services **(PA)** required after the initial 12 encounters are used in a calendar year	Deductible and coinsurance apply; no copayments apply	53
Inpatient and intermediate mental health care services **(PA)**	Deductible and coinsurance apply; no copayments apply	55
Behavioral Health Services for Chemical Dependency		
Outpatient chemical dependency services **(PA)** required after the initial 12 encounters are used in a calendar year	Deductible and coinsurance apply; no copayments apply	55
Inpatient and intermediate chemical dependency services **(PA)**	Deductible and coinsurance apply; no copayments apply	55
Other Health Services		
Ambulance services **(PA)**	Deductible and coinsurance apply; no copayments apply	56
Clinical trials **(PA)**	Deductible and coinsurance apply; no copayments apply	56

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Benefit Overview, continued
Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	Your Cost	Page
Other health services continued		
Durable medical equipment **(PA)**	Deductible and coinsurance apply; no copayments apply	57
Hearing aids **(PA), (BL)**	Deductible and coinsurance apply; no copayments apply	58
Home health care **(PA)**	Deductible and coinsurance apply; no copayments apply	58
Hospice care services **(PA)**	Deductible and coinsurance apply; no copayments apply	59
Injectable, infused or inhaled medications **(PA)**	Deductible and coinsurance apply; no copayments apply	59
Medical supplies **(PA)**	Deductible and coinsurance apply; no copayments apply	60
New cancer therapies or other life threatening diseases or conditions **(PA)**	Deductible and coinsurance apply; no copayments apply	60
Orthoses and prosthetic devices **(PA), (BL)**	Deductible and coinsurance apply; no copayments apply	60
Special medical formulas **(PA)**	Deductible and coinsurance apply; no copayments apply	60

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Chapter 1. Getting started as a member

SECTION 1 Introduction

Welcome to Neighborhood Health Plan of Rhode Island ("Neighborhood"). We are pleased that you have selected us. We want to make sure you understand the information in this *Certificate of Coverage* and that you are satisfied with the services you receive as a Neighborhood member. Please call Neighborhood *Member Services* at 1-800-459-6019 (TTY 1-401-459-6690) if you have any questions about your benefits or visit us at www.nhpri.org.

Section 1.1 You are enrolled in Neighborhood Exchange Health Plan which is an HMO

There are different types of health plans. Neighborhood's Exchange Health Plan is an HMO Plan (HMO stands for Health Maintenance Organization). We arrange for your healthcare through a network of contracted healthcare professionals and facilities. You will need to choose a *Primary Care Provider* (*PCP*), who will be responsible for managing your care.

Section 1.2 What the Certificate of Coverage booklet is about

This *certificate of coverage* booklet tells you how to get your health plan benefits covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

This plan, Neighborhood Exchange Health Plan, is offered by Neighborhood. (When this *certificate of coverage* says "we," "us," or "our," it means Neighborhood. When it says "plan" or "our plan," it means NHPRI Exchange Health Plan.

The word "*coverage*" and "*covered services*" refers to the medical care and services available to you as a member of NHPRI Exchange Health Plan.

Section 1.3 What this chapter tells you

Look through Chapter 1 of this *Certificate of Coverage* to learn:

- What makes you eligible to be a plan member?
- What is your plan's service area?
- What materials will you get from us?
- How do you keep the information in your *Membership* record up to date?

Section 1.4 If you are new to NHPRI Exchange Health Plan

If you are a new member, then it's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Certificate of coverage* booklet.

If you are confused or concerned or just have a question, please contact our plan's *Member Services*

Section 1.5 Legal information about the Certificate of Coverage

This *Certificate of Coverage* is part of our contract with you about how NHPRI's Exchange Health Plan *covers* your care. Other parts of this contract include your enrollment form and any notices you receive from us about changes to your *coverage* or conditions that affect your *coverage*. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in NHPRI's Exchange Health Plan.

SECTION 2 What makes you eligible to be a plan member

Section 2.1 An eligible person

You: Any person is eligible as a *subscriber* to enroll in *coverage* under this agreement if you:

- Maintain primary residence in our service area, Rhode Island, and
- Live in Rhode Island for at least 9 months in each period of 12 months*

*Note: The 12-month period begins with the first month you do not live in Rhode Island.

Your *spouse* or *child* is eligible as a *dependent* only if you are a *subscriber* and that *spouse* or *child*:

- Qualifies as a *dependent* as defined in this *certificate of coverage*.
- Children are not required to maintain primary residence in Rhode Island. However, care outside of Rhode Island is limited to *emergency* or urgent care only.

<u>If you live outside the Service Area**</u>

If you live outside the Service Area, you can be *covered* only if:

- You are a *child*; or
- You are a *dependent* subject to the Qualified Medical Child Support Order (QMCSO); or
- You are a divorced *spouse* Neighborhood must *cover*.

**Note: Care outside of the Service Area of Rhode Island is limited to Emergency or Urgent Care only.

Your *spouse*: Your spouse is eligible to enroll for *coverage* under this agreement, if you have selected *family coverage*. Only one of the following individuals may be enrolled at a given time:

- Your opposite sex spouse, according to the statutes of the state in which you were married, when your marriage was formed by obtaining a marriage license, having a marriage ceremony, and registering the marriage with the appropriate state or local official.
- Your common law spouse, according to the law of the state in which your marriage was formed (generally, common law spouses are of the opposite-sex). Your spouse by common law of the opposite gender is eligible to enroll for *coverage* under this agreement. To be eligible, you and your common law spouse must complete and sign our Affidavit of Common Law Marriage and send us the necessary proof. Please call us to obtain the Affidavit of Common Law Marriage.
- Your same-sex spouse, according to the laws of the state in which you were married, when your marriage was formed by obtaining a marriage license, having a marriage ceremony, and registering the marriage with the appropriate state or local official. Your same-sex spouse may be enrolled only if your marriage is recognized by the state in which you reside.
- Your civil union partner, according to the law of the state in which you entered into a civil union. Civil Union partners may be enrolled only if civil unions are recognized by the state in which you reside.
- Former *spouse*: In the event of a divorce, your former spouse will continue to be eligible for *coverage* provided that your divorce decree requires you to maintain continuing *coverage* under a family policy in accordance with state law. In that case, your former spouse will remain eligible on your policy until the earlier of:

- The date either you or your former spouse are remarried;
- The date provided by the judgment for divorce; or
- The date your former spouse has comparable *coverage* available through his or her own employment.

Domestic Partner: Your domestic partner is eligible to enroll for coverage under this agreement. You and your domestic partner must complete and sign our Declaration of Domestic Partnership and we must receive necessary proof.

Your Children: Each of your and your spouse's children are eligible for coverage up to the maximum *dependent* age shown in the Summary of Benefits, or as ordered by a Qualified Medical Child Support Order ("QMCSO"). For purposes of determining eligibility under this agreement, the term *child* means:

- Natural Children;
- Step-children;
- Legally Adopted Children: In accordance with Rhode Island General Law § 27-20-14, an adopted *child* will be considered eligible for *coverage* as of the date of placement for adoption with you by a licensed child placement agency;
- Foster Children: Your foster children who permanently live in your home are eligible to enroll for *coverage* under this agreement.

***Disabled dependent*s:** In accordance with Rhode Island General Law § 27-20-45, when your unmarried *child* who is enrolled for *coverage* under this agreement reaches the maximum *dependent child* age and is no longer considered eligible for *coverage*, he or she continues to be an *eligible person* under this agreement if he or she is a *disabled dependent*.

If you have an unmarried *child* of any age who is medically certified as disabled and is chiefly dependent on you for support and care because of mental impairment or physical disability, which can be expected to result in death or can be expected to last for a continuous period of not less than twelve months, that *child* is an eligible *dependent* under this agreement. If you have a *child* whom you believe satisfies these conditions, you must call us to obtain the form necessary to verify the *child*'s disabled status and show proof of the disability. This form must be filled out and submitted to us. Periodically thereafter, you may be asked to show proof that this disabling condition still exists to maintain *coverage* as a *dependent* for this *child*.

<u>Proof of eligibility</u>

We may ask you for proof of your and your *dependent*s' eligibility or continuing eligibility. You must give us proof when asked. This may include proof of residence, marital status, birth or adoption of a *child*, and legal responsibility for health care *coverage*.

Section 2.2 When you may enroll

When first eligible

You and your eligible *dependent*s may enroll by making written application to us through the *Exchange*. So long as we receive your Membership application within that timeframe and your Membership fees are paid, your *coverage* begins on the first day of the month following your submission of a complete application to us.

Special Enrollment Period

Adding dependents under *family coverage*

After your initial *effective date*, you may enroll your eligible *dependent*s for *coverage* through a Special Enrollment Period after you or your eligible *dependent*s experience a change in family status, a loss of private health *coverage*, or a change in eligibility for Medicaid or a State Children's Health Insurance Program (CHIP) as described below.

With a change in family status, you must make written application within the thirty-one (31) days following the event. You and/or your eligible *dependent*s will qualify for a Special Enrollment Period as follows:

- If you get married, *coverage* begins the first day of the month following your marriage.
- If you have a *child* born to the family, *coverage* begins on the date of the *child*'s birth.

  You must notify Neighborhood of the birth of a newborn *child* and pay us the required Premium within 31 days after the date of birth. Otherwise, that *child* will not be *covered* beyond the 31-day period. No coverage is provided for a newborn *child* who remains hospitalized beyond that 31-day period and has not been enrolled in this plan.
- If you have a *child* placed for adoption with your family, *coverage* begins on the date the *child* is placed for adoption with your family.

  You must enroll your *Adoptive Child* within 31 days after the *child* has been adopted or placed for adoption with you. This is required for that *child* to be *covered* from the date

of his or her adoption. Otherwise, you must wait until the next Open Enrollment Period to enroll the *child*.

Late Enrollment

You and/or your eligible *dependent*s may enroll following the initial enrollment period, and outside of the open enrollment or special enrollment periods. *Coverage* is effective the first day of the calendar month following the receipt of your completed application.

With a loss of private health *coverage*, you must make written application within the thirty-one (31) days following the event. *Coverage* begins the first day of the month following the loss of private health coverage. If you or your eligible *dependent*s have a loss of coverage on the first day of the month, *coverage* under this plan begins on the first day of that month. You or your eligible *dependent*s will qualify for a Special Enrollment Period if each of the following conditions is met:

- The *eligible person* seeking *coverage* had other coverage at the time that he or she was first eligible for *coverage* under this agreement;
- The person waived *coverage* under this plan due to being *covered* on another plan; and
- The coverage on the other plan is terminated as a result of:
    - Loss of eligibility for the *coverage* (including as a result of legal separation, divorce, death,
    - Termination of employment, or a reduction in the number of hours of employment),
    - Employer contributions towards such *coverage* being terminated, or
    - *COBRA*, due to continuation, is exhausted.

With a change in eligibility for Medicaid or a CHIP, you must make written application within sixty (60) days following your change in eligibility. *Coverage* will begin on either the first day of the month following the event or, if the event occurs on the first day of a month, coverage under this plan begins on the first day of that month. You and/or your eligible *dependent*s will qualify for a Special Enrollment Period as follows:

- You and/or your eligible *dependent* are terminated from Medicaid or CHIP *coverage* due to a loss of eligibility; or

- You and/or your eligible *dependent* become eligible for premium assistance, coverage, through Medicaid or CHIP.

Coverage for Members who are hospitalized on their *effective date*

If you are in the hospital on your *effective date* of *coverage*, health care services related to such hospitalization are *covered* as long as: (a) you notify us of your hospitalization within forty-eight (48) hours of the *effective date*, or as soon as is reasonably possible; and (b) *covered services* are received in accordance with the terms, conditions, exclusions and limitations of this agreement. As always, benefits paid in such situations are subject to the coordination of benefits provisions described in Chapter 9 Section 5.

Section 2.3 Continuing eligibility for dependents

When does *coverage* end?

Dependent coverage for a *child* ends on the *child*'s 26th birthday.

This age limit does not apply to a *child* who qualifies as a *disabled dependent* at any age.

Section 2.4 Neighborhood's plan service area

Neighborhood's Plan is available only to individuals who live in our plan service area. To remain a member of our plan, you must keep living in this service area. The service area, which is also the enrollment service area, is the geographical area within which we have developed a network of *provider*s to afford Members with adequate access to *covered services*. The Enrollment Service Area consists of the entire state of Rhode Island.

If you plan to move out of the service area, please contact *Member Services*

SECTION 3 Other materials will you get from us

Section 3.1 Your plan membership identification card – use it to get all *covered* care

Neighborhood gives each *member* a member identification card (Member ID card). While you are a member of our plan, you must use your Membership card whenever you get any services covered by this plan.

Please check your Member ID card for accuracy.

When you receive your Member ID card, check it carefully. If any information is wrong, call *Member Services*.

Identifying yourself as a Neighborhood Member

Your Member ID card is important; it identifies you as a Neighborhood *member*. Please:

- Carry you Member ID card at all times
- Have your Member ID card with you for medical, hospital and other appointments, and
- Show you member ID card to any *provider* before you receive healthcare services

If your Member ID card is lost, damaged or stolen

If your plan Member ID Card is damaged, lost, or stolen, call *Member Services* right away and we will send you a new card.

Membership requirement

You are eligible for benefits if you are a *member* when you receive care. A Member ID card alone is not enough to get you benefits. If you receive care when you are not a *member*, you are responsible for the cost.

Section 3.2 The Provider Directory: your guide to all providers in the plan's network

Every year that you are a member of our plan, we will send you either a new *provider* Directory or an update to your *Provider* Directory. This directory lists our *network provider*s.

What are "*network provider*s"?

Network *provider*s are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan *cost sharing* as payment in full. We have arranged for these *provider*s to deliver *covered services* to Members in our plan.

Why do you need to know which *provider*s are part of our network?

It is important to know which *provider*s are part of our network because, with limited exceptions, while you are a member of our plan you must use *network provider*s to get your medical care and services. The only exceptions are emergencies, urgently needed care when

the network is not available (generally, when you are out of the area) and cases in which Neighborhood authorizes use of *out-of-network provider*s. See Chapter 3 (Using the plan's coverage for your medical services) for more specific information about *emergency*, *out-of-network*, and out-of-area coverage.

If you don't have your copy of the *Provider* Directory, you can request a copy from *Member Services* at 855-321-XCHG (855-321-9244). You may ask *Member Services* for more information about our *network provider*s, including their qualifications. Additionally, Neighborhood's *Provider* Directory is available online at **www.nhpri.org**. You will be able to search the online directory to find all of the primary care doctors (*PCP*s), specialty doctors, behavioral health doctors, hospitals and urgent centers that participate in our network. Both *Member Services* and the website can give you the most up-to-date information about changes in our *network provider*s.

SECTION 4 Keep your plan membership record up to date

Section 4.1 How to help make sure that we have accurate information about you

Your Membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your *Primary Care Provider* (*PCP*).

The doctors, hospitals, and other *provider*s in the plan's network need to have correct information about you. **These *network provider*s use your Membership record to know what services are covered and the cost-sharing amounts for you**. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, Medicare or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you receive care in an out-of-area or *out-of-network* hospital or emergency room
- If your authorized representative (such as a caregiver) changes

- If you are participating in a clinical research study

If any of this information changes, please let us know by calling *Member Services*.

SECTION 5 We protect the privacy of your personal health information

Section 5.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.5 of this booklet.

Chapter 2. Important phone numbers and resources

SECTION 1 NHPRI Exchange Health Plan contacts (how to contact us)

How to contact our plan's *Member Services*

The *Member Services* Department is available to help answer your questions. For assistance with:

- How the Plan works
- Selecting a *Primary Care Provider* (*PCP*)
- Benefits
- Enrollment, eligibility
- Network *provider* information
- Member ID Cards
- *Claim*s and payment requests
- Inquiries, *complaint*s and *appeal*s
- Status of utilization reviews

Please call or write to Neighborhood's *Member Services*. We will be happy to help you.

Member Services	
CALL	855-321-XCHG (855-321-9244) Calls to this number are free. Hours of Operations are Monday - Friday 8:30 am – 5:00 pm *Member Services* also has free language interpreter services available for non-English speakers.

TTY	401-459-6690 Calls to this number are free. Hours of Operations are Monday - Friday 8:30 am – 5:00 pm
WRITE	*Member Services* Neighborhood Health Plan of Rhode Island 299 Promenade St. Providence, RI 02908
WEBSITE	www.nhpri.org

SECTION 2 Emergency medical care

Emergency Medical Care

To obtain *emergency* medical care: In an *emergency* seek care at the nearest emergency facility. If needed call 911 for emergency medical assistance. If 911 services are not available in your area, call the local number for *emergency* services.

SECTION 3 Routine or urgent care

Routine or Urgent Care

To obtain routine or urgent medical care: For routine and urgent care in the service area, always call you *PCP*.

SECTION 4 Mental health and chemical dependency services

Mental health and chemical dependency services

To obtain mental health and chemical dependency services: The Plan contracts with Beacon Health Strategies, LLC, to manage all mental health and *chemical dependency* services. If you need these services, you may do any of the following:

- Call the toll-free 24-hour mental health / *chemical dependency* telephone line – staffed by Beacon at 1-800-215-0058 for help finding a *network provider*

- Go directly to a *network provider* who provides mental health or *chemical dependency* services
- Call your *PCP*
- Visit Beacon's website www://beaconhealthstrategies.com or follow the link on the Plan's website

Chapter 3. Using the plan's coverage for your medical services

SECTION 1 Things to know about getting your medical care and prescription drugs covered

This chapter explains what you need to know about using the plan to get your medical care covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by the plan.

For the details on what medical care and prescription drugs are covered by our plan and how much you pay when you get these services, use the benefits information in the next chapter, Chapter 4 Covered services).

Section 1.1 "Network providers" and "covered services"

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- "*Providers*" are doctors and other health care professionals licensed by the state to provide medical services and care. The term "*providers*" also includes hospitals and other health care facilities.

- "Network *providers*" are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these *providers* to deliver *covered services* to Members in our plan. The *providers* in our network generally bill us directly for care they give you. When you see a *network provider*, you usually pay only your share of the cost for their services.

- "*Covered services*" include all the medical care, health care services, medications, supplies, and equipment that are covered by our plan. Your *covered services* for medical care are listed in Chapter 4.

Section 1.2 Basic rules for getting your medical care covered

NHPRI Exchange Health Plan will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits** (reference Chapter 4 of this booklet).

- **The care you receive is considered *medically necessary***. "*Medically necessary*" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You have a network *Primary Care Provider* (a *PCP*) who is providing and overseeing your care.** As a member of our plan, you must choose a network *PCP* (for more information about this, see Section 2.1 in this chapter).

    - In most situations, your network *PCP* must give you approval in advance before you can use other *provider*s in the plan's network, such as specialists, hospitals, *skilled* nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about this, see Section 2.3 of this chapter.

    - Referrals from your *PCP* are not required for *emergency* care or urgently needed care. There are also some other kinds of care you can get without having approval in advance from your *PCP* (for more information about this, see Section 2.2 of this chapter).

- **You must receive your care from a *network provider*** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-*network provider* (a *provider* who is not part of our plan's network) will not be covered. Here are two exceptions:

    - The plan covers *emergency* care or urgently needed care that you get from an *out-of-network provider*. For more information about this, and to see what *emergency* or urgently needed care means, see Section 3 in this chapter.

    - If you need medical care our plan is required to cover and the *provider*s in our network cannot provide this care, you can get this care from an *out-of-network provider*. An authorization must be obtained from Neighborhood prior to seeking care. In this situation, you will pay the same as you would pay if you got the care from a *network provider*. For information about getting approval to see an *out-of-network* doctor, see Section 2.4 in this chapter.

Section 1.3 Preauthorization

Preauthorization is required for certain *covered services*. Services that require *preauthorization* are marked with an asterisk (*) in the Summary of Medical Benefits.

If a *preauthorization* is required, Neighborhood will make a decision as expeditiously as your health condition might require, but no later than fifteen (15) calendar days from the receipt of the request. This timeframe may be extended by fifteen (15) calendar days if you request

it or NHRPI determines there is a need for additional information and documents (for example medical evidence) and the delay is in your best interest.

Your *network provider* is responsible for obtaining *preauthorization* for in-network *covered services*. You must request approval from Neighborhood prior to scheduling an appointment or receiving *covered services* from *non-network provider*s, by calling *Member Services* at 1-866-423-0945. Neighborhood's Medical Management Department will review your request for services.

Fast (expedited) *Preauthorization* Review

You may request an fast *preauthorization* review. NHRPI will expedite the request based on either of the following conditions:

- We find that applying the standard time for making a determination could seriously jeopardize your health, life, or ability to regain maximum function; or
- Your physician indicates, either orally or in writing, that applying the standard time for making a determination could seriously jeopardize your life or ability to regain maximum function.

Neighborhood will make a decision as expeditiously as your health condition might require, but no later than 72 hours after receipt of the request. This timeframe may be extended by fifteen (15) calendar days if you request it or NHRPI determines there is a need for additional information and documents (for example medical evidence) and the delay is in your best interest.

Prescription Drug *Preauthorization*

Prescription drugs for which *preauthorization* is required are marked with "PA" on the list of covered drugs on Neighborhood's website (www.nhpri,org)

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

- Preauthorization requests are reviewed by our Pharmacist and Physician Reviewer within 14 calendar days from the date when the request is received. If the preauthorization request is denied we send you written notification within 14 calendar days from the date when the request is received. If the preauthorization is approved we will notify your prescriber and Pharmacist via fax.

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

SECTION 2 Use providers in the plan's network to get your medical care

Section 2.1 You choose a Primary Care Provider (PCP) to provide and oversee your medical care

What is a "*PCP*" and what does the *PCP* do for you?

A primary care doctor is called a "*PCP*", which stands for "primary care physician or *provider*." You must choose a *PCP* when you enroll with NHRPI. Your *PCP*'s name and phone number will be on your Neighborhood Member ID card. Your *PCP* is the doctor who knows you best. Your *PCP* wants to keep you healthy. Be sure to tell him or her about your medical concerns, visits to other doctors, trips to the hospital or ER, and any injuries or sicknesses you experience.

You can call your doctor's office 24 hours a day, seven days a week. Someone will be there to help you get the care you need. If no one can take your call at your doctor's office, there will be an answering service or an answering machine. It will provide instructions for emergencies, instructions for leaving a message, directions for reaching your doctor, and/or a referral to another doctor who can help you. Your *PCP* will coordinate your care by treating you or referring you to specialty services.

Your *PCP* will:

- Help you decide what to do when you or your *child* has a medical problem;
- Provide routine care;
- Give you annual checkups, vaccinations and sees you for other visits;
- Coordinate your health care services and visits to other doctors;
- Order prescriptions or tests for you; and
- Give you advice and answer questions about your health care.

What are the Different Types of *PCP*s You May Choose From?

Family Doctor: A family doctor treats patients of all ages. A family doctor provides *preventive care* (immunizations and check-ups), care for acute and chronic illnesses (such as asthma and diabetes), and health education. Some family doctors also take care of prenatal patients and deliver babies.

Internal Medicine Doctor: Internal medicine doctors diagnose and treat the diseases that affect the body's organs or the body as a whole. A doctor who practices internal medicine is also sometimes called an internist. Internal medicine doctors care for adult patients.

Pediatrician: A pediatrician provides care to babies, children, and teenagers.

Nurse Practitioner: A registered nurse who is qualified to conduct physical examinations, select plans of treatment, order appropriate laboratory tests/procedures), prescribe medications, coordinate consultations and referrals, and provide health education.

OB/GYN: A doctor who specializes in the care of women. This includes pregnant women, women's reproductive organs, breasts, and sexual function. Your OB-GYN may also offer primary care services.

How do you choose your *PCP*?

You should choose a *PCP* from Neighborhood's *Provider* Directory. Our *Provider* Directory will tell you where the doctor's office is located, what languages he or she speaks, and what hours the office is open. You may want to consider one that is close to home, or is recommended by a friend. You may also refer to our website at www.nhpri.org to find out this information as well.

- You may already have a *provider* who is listed as a *PCP* in our directory. In most instances you may choose him or her as your *PCP*. Once you choose a *PCP* in our network, you must inform us of your choice.

- You may not have a *PCP* or your *provider* may not be listed in our *Provider* Directory. In either case, you may also call *Member Services* for help in choosing a *PCP*.

Contacting your new *PCP*

If you choose a new *provider* as your *PCP*, you should: •

- Contact your new *PCP* as soon as you join;

- Identify yourself as a new Neighborhood Plan *member*, to him or her;

- Ask your previous *provider* to transfer your medical records to your new *PCP*; and
- Make an appointment for a check-up or to meet your *PCP*.

Changing your *PCP*

You may change your *PCP* or your *child*'s primary care doctor for any reason, at any time. Also, it's possible that your *PCP* might leave our plan's network of *provider*s and you would have to find a new *PCP*.

For a list of all primary care doctors in the Neighborhood Network, visit our website at www.nhpri.org. You can also request a copy of this information by calling *Member Services* at 1-800-459-6019.

Please call Neighborhood's *Member Services* for assistance if the primary care doctor listed on your member ID card or your *child*'s card is not correct, or if you would like to choose another primary care doctor for you or your *child*.

What happens if your *PCP* leaves the Neighborhood network?

We will send you a letter to inform you of this change. You can choose another *PCP* from the Neighborhood network or you will be assigned to one near your home. Please call Neighborhood *Member Services* at 855-321-XCHG (855-321-9244) if you need help choosing a new *PCP*.

Section 2.2 The kinds of medical care can you get without getting approval in advance from your *PCP*

A self-referral is when you make an appointment at a specialty care office without talking with your *PCP* first. If you self-refer to a specialist's office, choose a doctor who is in Neighborhood's *provider* network. Make sure you tell your *PCP* about the visit. Below are doctors you can make an appointment with or obtain services from without getting approval in advance from your *PCP* or Neighborhood.

- *Emergency* services from *network provider*s or from *out-of-network provider*s - both in Rhode Island and outside of Rhode Island. (Note: if admitted as an *inpatient*, you or someone acting for you should call your *PCP* or Neighborhood within 48 hours of receiving care).
- Urgently needed care services at a facility or walk in clinic - from in-*network provider*s or from *out-of-network provider*s when *network provider*s are temporarily unavailable or inaccessible; for example when you are temporarily outside of the plan's service area.

(Note: You must contact your *PCP* for follow up care after urgent care *covered services* are rendered.)

- Obstetric (pregnancy) / gynecological (women's care): routine visits, exams and *medically necessary* follow-up care and services
- Behavioral health services (mental health and *chemical dependency* services)
- Family planning, counseling, or birth control visits
- Routine eye exams every
- Diabetic eye exam (every year)
- Childbirth education and parenting classes
- Smoking cessation programs to help you quit
- Sexually transmitted disease (STD) treatment through the RI Department of Health

Section 2.3 Getting care from specialists and other network providers

A specialty care doctor, or specialist, is a doctor who cares for a specific part of the body or for a specific disease. Specialty care doctors have extra training /education about that area of the body or that disease. Your primary care doctor (*PCP*) is responsible for your regular care and checkups. He or she helps you see a specialist when you need one.

Some examples of specialty doctors include:

- **Obstetrician / gynecologist**: An obstetrician / gynecologist is a doctor who provides women's medical care, diagnosis, and treatment of disorders in the female reproductive system, and provides care for pregnant women.
- **Gynecologist**: A gynecologist diagnoses and treats diseases of the female reproductive system.
- **Obstetrician**: An obstetrician cares for women who are pregnant and delivers babies.
- **Podiatrist**: A podiatrist is a physician that specializes in the evaluation and treatment of diseases of the foot.
- **Optometrist**: An optometrist is a health care professional who is licensed to provide eye care services.

- **Ophthalmologist**: A medical doctor specializing in the treatment of diseases of the eye.
- **Endocrinologist**: A medical doctor who specializes in the diagnosis and treatment of disorder of the glands, for example, diabetes or thyroid disorders.
- **Women's health specialist**: A medical doctor or practitioner specializing in the treatment of women's health needs, including family planning. Women's health specialists include, but are not limited to, obstetricians, gynecologists, and certified nurse midwives.
- **Oncologists**: An oncologist cares for patients with cancer.
- **Cardiologists**: A medical doctor specializing in the care of patients with heart conditions.
- **Orthopedists**: An orthopedist cares for patients with certain bone, joint, or muscle conditions.

What is a referral?

Your primary care doctor (*PCP*) may decide you should see a specialist. He or she will give you a referral. A referral means your doctor recommends this specialist to diagnose and treat your condition. Your primary care doctor (*PCP*) will contact the specialist and let that office know you will be scheduling an appointment. Make sure you give your doctor enough time to call the specialist before you make an appointment. Sometimes—but not very often—you will need approval from Neighborhood before seeing a specialist. After your doctor recommends a specialist, the specialist will contact Neighborhood to get permission to care for you.

What if a specialist or another *network provider* leaves our plan?

Sometimes a specialist, clinic, hospital or other *network provider* you are using might leave the plan. Our Neighborhood *Member Services* Specialists will help you with selecting another *provider*.

In special circumstances, Neighborhood will temporarily allow you to continue receiving services and care from your *PCP* or specialty care doctor even if she or he leaves our *provider* network. Some special cases might be if you are being treated for an ongoing condition or if you are pregnant. This is because your relationship with your doctor is important. We will work with you and your doctor to ensure a safe and comfortable transition of your health care to another doctor. Please call Neighborhood *Member Services* at 855-321-XCHG (855-321-9244) if your *provider* decides to leave our network and you need to continue to seeing him or her for a while.

Section 2.4 Getting care from out-of-network providers

You might need health care services when you are "out of area". This means you are too far away to receive care from a doctor or hospital in Neighborhood's network. *Emergency* services are always covered when you are out of area. If you are experiencing an *emergency* call 911 immediately or visit the nearest emergency room. Call your primary care doctor when you return home to tell them what happened. If you received a bill for *emergency* services you received out of area, send it to Neighborhood's *Member Services* department.

All other covered health care services, care and services provided "out of area" need to be approved by Neighborhood by first calling *Member Services* at 855-321-XCHG (855-321-9244).

Sometimes you may need care from a local doctor who is not in Neighborhood's *provider* network. This doctor is "out of network". To see an "out of network" doctor, you'll need approval from Neighborhood before you make the appointment by calling Neighborhood *Member Services* at 855-321-XCHG (855-321-9244). If you do not receive approval to see and "out of network" provider you will be responsible for the cost of services.

Requests for services for non-*emergency* care from doctors who are not in NNPRI's network are considered if one (1) of the following are met:

- The services requested are not available in Neighborhood's network.
- Doctors with the same expertise are not available in Neighborhood's network.
- You are getting treatment for an acute medical condition, a chronic condition, or are in your 2nd or 3rd trimester of pregnancy and your doctor leaves the Neighborhood network.
- You are getting follow up care from *emergency* services.
- You have an ongoing relationship with a primary care or specialty care doctor.

Neighborhood's Medical Management team will make a decision within 15 calendar days from when the request for an *out-of-network* service is received. If more information is needed to help Neighborhood make a care decision, you will be notified that the decision timeframe has been extended. Requests for *out-of-network* services that are urgent are responded to within 72 hours.

You may request an fast *preauthorization* review for out-of-network services. NHRPI will expedite the request based on either of the following conditions:

- We find that applying the standard time for making a determination could seriously jeopardize your health, life, or ability to regain maximum function; or

- Your physician indicates, either orally or in writing, that applying the standard time for making a determination could seriously jeopardize your life or ability to regain maximum function.

Neighborhood will make a decision as expeditiously as your health condition might require, but no later than 72 hours after receipt of the request.

If you receive *covered services* from a doctor who is not in our network and you do not get approval from Neighborhood first, you may have to pay for the services. *Covered services* provided by non-Neighborhood Plan *provider*s are not paid for unless approved by Neighborhood before you make the appointment or receive the service. Contact Member Services. Our Medical Management team will review your request.

SECTION 3 Getting covered services when you have an emergency or urgent need for care

Section 3.1 Getting care if you have a medical emergency

What is a "medical *emergency*" and what should you do if you have one?

An "***emergency* medical condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition:

- Placing the health of the individual, or with respect to a pregnant woman her unborn *child* in serious jeopardy;

- Constituting a serious impairment to bodily functions; or

- Constituting a serious dysfunction of any bodily organ or part.

The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Examples of some types of emergencies are:

- Broken bones

- Poisoning or swallowing a dangerous substance

- Drug overdose
- Very bad pain or pressure
- Bleeding that will not stop
- Severe trouble breathing
- Change in level of consciousness
- Bad head injury
- Seizures (or a change in pattern of seizures)
- Complications of pregnancy such as persistent bleeding or severe pain
- Thoughts of Suicide

If you have a medical *emergency*:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do not need to get approval or a referral first from your *PCP*. The hospital does not need to be part of Neighborhood's network.
- **You may need to receive services in the hospital once your *emergency* condition has been taken care of.** These are call post stabilization services or care and services given to you to make sure another *emergency* does not happened. Your doctor will make sure you receive the care you need so that you can safely return home. Call your *PCP* within 48 hours to tell him/ her about your *emergency* visit.
- **As soon as possible, make sure that our plan has been told about your *emergency*.** We need to follow up on your *emergency* care. You or someone else should call to tell us about your *emergency* care, usually within 48 hours. Call our *Member Services* Department at 855-321-XCHG (855-321-9244).

What is covered if you have a medical *emergency*?

You may get covered *emergency* medical care whenever you need it, anywhere in the United States and territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits description in Chapter 4 of this booklet.

If you have an *emergency*, we will talk with the doctors who are giving you *emergency* care to help manage and follow up on your care. The doctors who are giving you *emergency* care will decide when your condition is stable and the medical *emergency* is over.

After the *emergency* is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your *emergency* care is provided by *out-of-network provider*s, we will try to arrange for *network provider*s to take over your care as soon as your medical condition and the circumstances allow.

We may not cover continued out of-network services after the *emergency* condition is treated and stabilized. This may happen if we determine, in coordination with the *member*'s *provider*s, that the *member* is safe for transport back into the Service Area and that transport is appropriate and cost-effective.

What if it wasn't a medical *emergency*?

Sometimes it can be hard to know if you have a medical *emergency*. For example, you might go in for *emergency* care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical *emergency* after all. If it turns out that it was not an *emergency*, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was not an *emergency*, we will cover additional care only if you get the additional care in one of these two ways:

- You go to a *network provider* to get the additional care, or
- The additional care you get is considered "urgently needed care" and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

Section 3.2 Getting care when you have an urgent need for care

What is "urgently needed care"?

"Urgently needed care" is a non-*emergency*, unforeseen medical illness, injury, or condition, that requires immediate medical care. Urgently needed care may be furnished by in-*network provider*s or by *out-of-network provider*s when *network provider*s are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in the plan's service area when you have an urgent need for care?

In most situations, if you are in the plan's service area, we will cover urgently needed care only if you get this care from a *network provider* and follow the other rules described earlier in this chapter. However, if the circumstances are unusual or extraordinary, and *network provider*s are temporarily unavailable or inaccessible, we will cover urgently needed care that you get from an *out-of-network provider*.

If you or your *child* needs urgent care, call your primary care doctor's office. Say you need to schedule a "sick visit." Your doctor should give you an appointment within 24 hours, or, he or she will direct you to an urgent care center in Neighborhood's network. Urgent care sites are helpful when you have a problem that needs to be seen that day but your doctor's office cannot give you an appointment. Here are some examples of problems that need urgent care:

- A sore throat
- Skin rash
- Pink eye
- Low grade fever
- Ear infection
- Mild or moderate trouble breathing
- Runny nose
- Coughing
- Persistent diarrhea

For more information about urgent care centers in your community, search the Neighborhood *Provider* Directory online at www.nhpri.org or call Neighborhood *Member Services* at 855-321-XCHG (855-321-9244)

What if you are <u>outside</u> the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a *network provider*, our plan will cover urgently needed care that you get from any *provider*. If this happens, we recommend that you or someone acting for you contact your *PCP*. You need to do this to arrange for any necessary follow-up care.

We may not cover continued services after the Urgent condition is treated and stabilized. This may happen if we determine, in coordination with the *member*'s *provider*s, that: (1) the *member* is safe for transport back into the Service Area; and: (2) that transport is appropriate and cost-effective

Our plan does not cover urgently needed care or any other care if you receive the care outside of the United States.

SECTION 4 If you are billed directly for the full cost of your covered services

Section 4.1 You can ask us to pay our share of the cost of covered services

If a doctor or hospital sends you a bill or if you paid for *covered services*, Neighborhood will help you resolve the issue. Neighborhood will pay you back when appropriate. To better help you, please make sure you let Neighborhood know as soon as you receive any bill. You can send the receipts to:

Member Services
Neighborhood Health Plan of Rhode Island
299 Promenade Street
Providence, RI 02908

This includes *emergency* services received out-of-area.

Section 4.2 If services are not covered by our plan, you must pay the full cost

NHPRI's Exchange Health Plan covers all medical services that are *medically necessary*, are listed in the plan's Medical and Pharmacy Benefits Description (this is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan *covered services*, or they were obtained *out-of-network* and were not authorized.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. If we say we will not cover your services, you have the right to *appeal* our decision not to cover your care.

Chapter 7 (What to do if you have a problem or complaint (coverage decisions, *appeal*s, *complaint*s) has more information about what to do if you want a coverage decision from us or want to *appeal* a decision we have already made. You may also call *Member Services* to get more information about how to do this.

For *covered services* that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. Funds used by a member to pay for services after a benefit limitation has been reached do not count towards the Out-of-Pocket Maximum. Instead, the member is responsible for the full cost of the services not subject to any maximum amount.

You can call *Member Services* when you want to know how much of your benefit limit you have already used.

Chapter 4. Covered health care services

SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter focuses on your *covered services* and what you pay for your medical benefits. It includes a list of *covered services* as a member of NHPRI Exchange Health Plan. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of *out-of-pocket* costs you may pay for your *covered services*.

- The **"*deductible*"** is the amount you must pay for medical services before our plan begins to pay its share.
- A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a *copayment* at the time you get the medical service.
- **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a *coinsurance* at the time you get the medical service.

Section 1.2 Your yearly plan deductible

An **individual *deductible*** of [$260-$3,250] per member per *contract year* applies to each *member* for *covered services* received (Medical $250-$3,000 and Pharmacy $10-$250)

A **family *deductible*** of [$520-$6,500] per family per *contract year* applies for all enrolled Members of a family for *covered services* received (Medical $500-$6,000 and Pharmacy $20-$500)

Your *deductible* is the amount you have to pay *out-of-pocket* before we will pay our share for your covered medical services.

Until you have paid the *deductible* amount, you must pay the full cost of your *covered services*. Once you have paid your *deductible*, we will begin to pay our share of the costs for covered medical services and you will pay your share, including your *copayment* or *coinsurance* amount, for the rest of the calendar year.

All amounts any enrolled Members in a family pay toward their individual *deductible*s are applied toward the family *deductible*.

Once the family *deductible* has been met during a *contract year*, all enrolled Members in a family will thereafter have satisfied their individual *deductible*s for the remainder of that *contract year*.

Please note that any amount paid by the *member* for a *covered service* rendered during the last 3 months of a *contract year* will be carried forward to the next *contract year*'s *deductible*.

The *deductible* does not apply to some services. This means that we will pay our share of the costs for these services even if you have not paid your yearly *deductible* yet. The *deductible* does not apply to the following services:

- Mental Health services in a *provider*'s office or in your home
- Outpatient cardiac *rehabilitation*
- Diabetic podiatric office visits
- Diagnostic hearing tests
- Emergency room services
- House calls
- Asthma education visits
- Hospital based clinic visits
- Office visits
- Pediatric office visits
- Podiatrist services
- Adult immunizations
- Smoking cessation counseling
- Vision care services
- *Chemical dependency* treatment in a *provider*'s office or in your home
- Chiropractic medicine
- Diabetic vision care services
- Early intervention services
- Hemophilia services in a doctor's office
- Allergist and dermatologist visits
- Diabetes education
- Nutritional counseling
- Specialist visits
- Urgent care visits
- Prevention and early detection services
- Pediatric immunizations
- Surgery in a doctor's office

Section 1.3 The most you will pay for covered medical services

Out-of-Pocket Maximum (Individual)

This *Certificate of Coverage* has an individual *out-of-pocket maximum* of [$850-$6,000] per member per *contract year* for all *covered services*. Only copayments, *deductible*s, and *coinsurance* count toward the *out-of-pocket maximum* (Medical $750-$5,000 and Dental $100-$1,000)

Out-of-Pocket Maximum (Family)

The family *out-of-pocket maximum* of [$1,700-$12,000] is satisfied in a *contract year* by adding the amount of covered health care expenses applied to the out-of- pocket maximum for all family members (Medical $1,500-$10,000 and Pharmacy $200-$2,000)

No one (1) family member can contribute more than [$850-$6,000] towards the *contract year* family out-of- pocket maximum (Medical $750-$5,000 and Pharmacy $100-$1,000)

All amounts any enrolled Members in a family pay toward their Individual *out-of-pocket maximum*s are applied toward the [$1,700-$12,000] family *out-of-pocket maximum* (Medical $1,500-$10,000 and Pharmacy $200-$2,000)

Once the family *out-of-pocket maximum* has been met during a *contract year*, all enrolled Members in a family will have satisfied their $850-$6,000] individual *out-of-pocket maximum*s for the remainder of that *contract year* (Medical $750-$5,000 and Pharmacy $100-$1,000)

Section 1.4 Our plan does not allow providers to "balance bill" you

As a member of NHPRI Exchange Health Plan, an important protection for you is that after you meet any *deductible*s, you only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow *provider*s to add additional separate charges, called "*balance billing*." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the *provider* less than the *provider charges* for a service and even if there is a dispute and we do not pay certain *provider* charges.

Here is how this protection works.

If your *cost sharing* is a *copayment* (a set amount of dollars, for example, $15.00), then you pay only that amount for any *covered services* from a *network provider*.

If your *cost sharing* is a *coinsurance* (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of *provider* you see:

- If you receive the *covered services* from a *network provider*, you pay the *coinsurance* percentage multiplied by the plan's reimbursement rate (as determined in the contract between the *provider* and the plan).

- If you receive the *covered services* from an *out-of-network provider*, you pay the *coinsurance* percentage multiplied by the plan's reimbursement rate for *out-of-network*

*provider*s. (Remember, the plan covers services from *out-of-network provider*s only in certain situations, such as in an *emergency* or when you get a referral to a *provider* for services not able to be provided in the network.)

SECTION 2 Medical benefits

Section 2.1 Your medical benefits

The Medical Benefits on the following pages lists the services NHPRI Exchange Health Plan covers and what you pay *out-of-pocket* for each service. Health care services and supplies are *covered services* only when the following requirements are met:

- They are listed as *covered services* in this chapter and are consistent with applicable state or federal law;
- Your *covered services* must be provided according to the coverage guidelines established by Neighborhood and in effect at the time the services or supplies are provided.
- Your services (including medical care, services, medications, supplies, and equipment) must be *medically necessary*. "*Medically necessary*" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- Services are obtained within the 50 United States and territories. The only exceptions to this rule are *emergency* care services or urgent care services while traveling, which are *covered services* when provided outside of the 50 United States.
- You receive your care from a *network provider*. In most cases, care you receive from an *out-of-network provider* will not be covered. Chapter 3 provides more information about requirements for using *network provider*s and the situations when we will cover services from an *out-of-network provider*.
- You have a *Primary Care Provider* (a *PCP*) who is providing and overseeing your care. In most situations, your *PCP* must give you approval in advance before you can see other *provider*s in the plan's network. This is called giving you a "referral." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Medical Benefits section are covered only if your doctor or other *network provider* gets approval in advance (sometimes called

"*preauthorization*") from us. *Covered services* that need approval in advance are marked in the Summary of Medical Benefits section by a footnote [Insert if applicable: In addition, the following services not listed require *preauthorization*: [insert list]].

- For all preventive services, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a *copayment* will apply for the care received for the existing medical condition.

Important Notes:

A covered service is one which is described in this chapter. We will only pay *claim*s that are for *covered services*.

Pre authorization is required for certain *covered services*. We only cover a service listed in this *Certificate* if we or our designee determine that the care is *medically necessary*.

- For services you receive in-network, your *network provider* is responsible for obtaining pre authorization.

- For services you receive from a *non-network provider*, you must obtain the *preauthorization* by contacting Neighborhood *Member Services*. The only exceptions are emergencies (in or out of the service area) and urgently needed care when the network is not available (generally, when you are out of the service area.)

Covered Services

The following section describes services that qualify as *covered services*.

For information about your costs for the *covered services* listed below (for example, copayments, coinsurance, deductibles and *out-of-pocket maximum*s), see the "Summary of Benefits" section in this *Certificate*.

Please note that your coverage level under this plan will be different for preventive services and diagnostic services:

Preventive care services described in the PPACA guidelines, including women's preventive health services and preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms are covered in full.

You may need to pay a *cost sharing* amount for diagnostic procedures (including diagnostic colonoscopies, endoscopies, and proctosigmoidoscopies) and diagnostic mammograms.

The Summary of Benefits lists information about the day, dollar, and visit limits under this plan. Certain limits are also included in some *covered services* listed below.

Emergency care

Services that are required to stabilize or start treatment for an *emergency* in an emergency room or in a physician's office are covered.

Benefits include the facility charge, supplies and all professional services.

You may receive *emergency covered services* from a *non-network provider*. In this case, Neighborhood will pay up to the reasonable charge.

The emergency room *copayment* is waived if the emergency room visit results in hospitalization within 24 hours.

Outpatient care

Allergy testing

Allergy testing (including antigens) and treatment, and allergy injections are covered.

Cardiac *rehabilitation* services Cardiac *rehabilitation* services

Outpatient treatment of documented cardiovascular disease is covered.

We cover only the following services:

- The *outpatient* convalescent phase of the *rehabilitation* program following hospital discharge; and
- The *outpatient* phase of the program that addresses multiple risk reduction, adjustment to illness and therapeutic exercise.

We do not cover the program phase that maintains rehabilitated cardiovascular health.

The benefit is limited to up to 24 weeks based on medical necessity.

Chemotherapy

Chiropractic

Chiropractic treatment is covered to restore or improve motion, reduce pain and improve function in a neuromusculoskeletal condition.

The benefit is limited to 12 visits per *contract year*.

Contraceptive Services

Coverage is provided for *outpatient* contraceptive services, in accordance with RI General Law §27-20-43. This includes consultations, procedures and medical services. These services must be related to the use of all contraceptive methods approved by the United States Food and Drug Administration.

Procedures include sterilization.

Covered services include:

- Medical examinations;
- Birth control counseling;
- Consultations;
- Genetic counseling.

Covered contraceptives include*

- Cervical caps;
- Implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants);
- Intrauterine devices (IUDs);
- Depo-Provera or its generic equivalent;
- Any other *Medically necessary* contraceptive device approved by the United States Food and Drug Administration.

* We cover certain contraceptives under a Prescription Drug Benefit. Those contraceptives include oral contraceptives and diaphragms. If those contraceptives are covered under that benefit, they are not covered here.

Diabetes Services and Supplies

In accordance with Rhode Island General Law § 27-18-38, coverage is provided for the following services and supplies for the treatment of insulin treated diabetes, non-insulin treated diabetes, or gestational diabetes, when *medically necessary* and prescribed by a physician:

- Blood glucose monitors and blood glucose monitors for the legally blind and therapeutic/ molded shoes for the prevention of amputation are covered as *Durable Medical Equipment*;
- Insulin pumps and related supplies and insulin infusion devices are covered as Medical Supplies.
- Test strips for glucose monitors insulin, insulin syringes and oral agents for controlling blood sugar that are included on our list of covered drugs are covered under your Prescription Drug Benefit (for a list of covered drugs go to www.nhpri.org or call our Member Services representative at 855-321-XCHG (855-321-9244); and

Diabetes self-management education, including medical nutrition therapy is also covered. This coverage for self-management education and education relating to medical nutrition therapy is limited to *medically necessary* visits upon the diagnosis of diabetes, where a physician diagnoses a significant change in the *member*'s symptoms or conditions which necessitate changes in a *member*'s self-management, or where reeducation or refresher training is necessary. This education, when *medically necessary* and prescribed by a physician, may be provided only by the physician or, upon his or her referral to an appropriately licensed and certified health care *provider* and may be conducted in group settings.

Coverage for self-management education and education relating to medical nutrition therapy may also include home visits when *medically necessary*.

Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care for Members with diabetes.

Upon the approval of the United States Food and Drug Administration, new or improved diabetes equipment and supplies will be covered when *medically necessary* and prescribed by a physician.

Diagnostic imaging

Coverage includes general imaging (such as x-rays and ultrasounds) and MRI/ MRA, CT/ CTA, and PET tests and nuclear cardiology.

Early intervention services

In accordance with RI General Law § 27-20-50, Preventive and primary services for a *Dependent child* younger than three years of age who is certified by the Rhode Island Department of Human Services as eligible for early intervention services are covered.

Early intervention services must be provided by a licensed *provider* designated by the Department of Human Services as an "early intervention *provider*" and who works in early intervention programs approved by the Department of Health.

Covered services include, but are not limited to:

- Evaluation and case management;
- Nursing care,
- Occupational therapy,
- Physical therapy,
- Speech and language therapy,
- Nutrition;
- Service plan development and review; and
- Assistive technology services and devices consistent with early intervention programs approved by the Department of Health.

Coverage limited to a benefit of five thousand dollars ($5,000) per dependent child per policy or calendar year.

Hemodialysis Services

Outpatient hemodialysis and peritoneal dialysis, including home dialysis are covered.

Human leukocyte antigen testing or histocompatibility locus antigen testing

In accordance with RI General Law § 27-20-36, testing is covered when it is necessary to establish a *member*'s bone marrow transplant donor suitability. Coverage includes the costs of testing for A, B or DR antigens. Testing must be performed at a facility accredited by the American Association of Blood Banks or its successors. At the time of the testing, the tested person must complete and sign an informed consent form that also authorizes use of the results of the test for participation in the National Marrow Donor Program.

Coverage limited to one test per lifetime for each subscriber.

Immunizations

We cover preventive vaccinations and immunizations in accordance with current guidelines. These guidelines are subject to change. Our allowance includes the administration and the vaccine.

If any of the above immunizations are provided as part of an office visit, only your office visit *copayment* and *deductible* (if any) will be applied.

Infertility services

In accordance with Rhode Island General Law § 27-18-30, coverage is provided for *medically necessary* diagnosis and treatment of infertility. We only cover these services for a woman who is:

- Between the ages of 25 and 42;
- Married, in accordance to the laws of the state in which she resides;
- Unable to conceive or sustain a pregnancy during a period of one year; and
- A presumably healthy individual.

Procedures are covered for the diagnosis and treatment of infertility to the extent that they are used in the diagnosis or treatment of conditions other than infertility.

Oral and injectable drug therapies may be used to treat infertility. These therapies are covered under your Prescription Drug Benefit.

Covered infertility procedures are covered up to a lifetime maximum of $100,000.

Laboratory tests

Covered laboratory tests include, but are not limited to blood tests, urinalysis, throat cultures, glycosolated hemoglobin (A1c) tests, genetic testing, and urinary protein/microalbumin and lipid profiles.

Laboratory tests must be ordered by a physician, physician assistant, or nurse practitioner. The lab tests must also be performed at a licensed laboratory.

Covered laboratory tests are not subject to the *deductible* when associated with routine *preventive care*.

Lead screenings

Lead screening related services, and diagnostic evaluations for lead poisoning are covered in accordance with Rhode Island law.

Lyme disease

Medically necessary diagnostic testing and long-term antibiotic treatment of chronic Lyme disease are covered when ordered by a physician after a thorough evaluation of the patient's symptoms, diagnostic test results and response to treatment. Treatment otherwise eligible for benefits will not be denied solely because it may be considered as unproven, *experimental*, or investigational, in accordance with Rhode Island General Law §27-18-62.

Nutritional counseling

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

Oral health services

The following oral services are covered. If you want to make sure that a planned service is a covered service, call *Member Services*.

Emergency care

X-rays and *emergency* oral surgery in a physician’s office or emergency room must be done to temporarily stabilize damaged tissues or reposition sound, natural and permanent teeth that have moved or have broken due to injury. You must receive this care within 48 hours after the injury. The injury must have been caused by a source outside the mouth.

Non-Emergency Hospital, physician, and surgical charges for the following conditions:

- Surgical treatment of skeletal jaw deformities; or
- Surgical treatment for Temporomandibular Joint Disorder (TMJ).
- In certain specific instances, the costs of *inpatient* services and day surgery for certain additional oral health services are covered.

Outpatient *free- standing ambulatory surgi-center*

Outpatient surgery done under anesthesia in an operating room of a facility licensed to perform surgery is covered. You must be expected to be discharged the same day and be shown on the facility's census as an *outpatient*.

Outpatient surgery in a physician's office

Podiatrist Services

Office visits to the podiatrist are covered.

Routine foot care is not covered. Routine foot care includes the treatment of corns, bunions (except capsular or bone surgery) calluses, the trimming of nails, the treatment of simple ingrown nails and other preventive hygienic procedures, except when performed to treat diabetic related nerve and circulation disorders of the feet.

Corrective or orthopedic shoes and orthotic devices used in connection with footwear are only covered for the treatment of diabetes.

The treatment of flat feet is not covered unless the treatment is surgical.

Preventive care for Members through age 19

Pediatric *preventive care* coverage for a *child* from birth to age 19 is provided in accordance with the American Academy of Pediatrics guidelines and as required by Rhode Island General Laws Section § 27-38.1.

Any *medically necessary* follow-up care as a result of a routine physical exam is subject to a *cost sharing* amount.

Preventive care for Members age 20 and over

Routine physical examinations including appropriate immunizations and lab tests as recommended by a *provider*;

Routine annual gynecological exam, including any *medically necessary* follow-up obstetric or gynecological care based on that exam;

- Per Rhode Island General Laws Section §27-41-45 women may receive an annual visit to an in-network obstetrician/ gynecologist for routine gynecological care without a referral from their *Primary Care Provider*.

Hearing examinations and screenings.

Any *medically necessary* follow-up care as a result of a routine physical or routine annual gynecological exam is subject to a *cost sharing* amount.

Prevention and Early Detection Services

Your coverage level will be different for preventive screenings (covered in full) versus diagnostic services (subject to member *cost sharing*).

Preventive care services include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.

- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

- With respect to infants, children and adolescents, evidence-informed *preventive care* and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

- With respect to women, such additional *preventive care* and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

For example, coverage is provided for the following preventive screenings:

- Preventive screenings for colon and colorectal cancer. Examples include colonoscopy and sigmoidoscopy screenings.

- Routine Pap smears including coverage for one annual screening for women age 18 and older in accordance with guidelines established by the American Cancer Society.
- Routine mammograms in accordance with guidelines established by the American Cancer Society.
- Two (2) screening mammograms per year are covered when recommended by a physician for women who have been treated for breast cancer within the last 5 years or are at high risk of developing breast cancer due to genetic predisposition (BRCA gene mutation or multiple first degree relatives) or high risk lesion on prior biopsy (lobular carcinoma in situ) or atypical ductal hyperplasia.
- Prostate and colorectal examinations and laboratory tests for cancer for any non-symptomatic *member*, in accordance with the current American cancer society guidelines.

Radiation therapy

Respiratory therapy or pulmonary *rehabilitation* services

Rehabilitation services must be performed by a physician or by a licensed therapy *provider*. Benefits under this Section include *rehabilitation* services provided in a physician's office or on an *outpatient* basis at a hospital or alternate facility.

Short term speech, physical and occupational therapy services

These services are covered when provided to restore function lost or impaired as the result of an accidental injury or illness. They are also covered to include not only the improvement of function but also the halting or slowing the progression of primary and secondary disabilities, maintaining functioning and prevention of further deterioration.

Habilitative health care services that help a person keep, learn or improve skills and functioning for daily living are covered. An example is therapy for a *child* who is not walking or talking at the expected age. These services may include physical an occupational therapy, speech-language therapy and other services for people with disabilities in a variety of *inpatient* and/or *outpatient* settings.

Smoking cessation counseling sessions

Coverage is provided for individual, group, and telephonic smoking cessation counseling services that:

- Are provided in accordance with current guidelines established by the United States Department of Health and Human Services; and
- Meet the requirements of Rhode Island Office of the Health Insurance Commissioner Regulation 14 and in accordance with Rhode Island General Law§27-18-6.
- Coverage is also provided for prescription and over-the-counter smoking cessation agents. For more information, see the Prescription Drug Benefits section of this *Certificate*.

Vision care

Vision care services for members under age 21 and adults

Routine vision examination

- One routine vision examination per *contract year* is covered. This includes:
- New patient exam;
- Established patient exam;
- Routine ophthalmologic exam with refraction for new or established patient.

Instead of a complete exam, we will cover retinoscopy (when applicable) which includes objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Eyeglasses

- One pair of lenses is covered every *contract year* including:
- Single vision lenses;
- Conventional (lined) bifocal lenses;
- Conventional (lined) trifocal lenses; and
- Lenticular lenses

Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, and lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses.

Polycarbonate lenses are covered in full for Children, monocular patients and patients with prescriptions > +/- 6.00 diopters.

All lenses include scratch resistant coating with no additional cost-sharing amount.

Frames are also covered once every *contract year*.

You are eligible to select only one of either eyeglasses (eyeglass lenses and/ or eyeglass frames) or contact lenses. If you select more than one of these vision care services, we will pay benefits for only one vision care service.

Other Vision Services

- Optional Lenses and Treatments:
- Ultraviolet Protective Coating
- Polycarbonate Lenses
- Blended Segment Lenses
- Intermediate Vision Lenses
- Standard Progressives
- Premium Progressives (Varilux®, etc.)
- Photochromic Glass Lenses
- Plastic Photosensitive Lenses (Transitions®)
- Polarized Lenses
- Standard Anti-Reflective (AR) Coating
- Premium AR Coating
- Ultra AR Coating

- Hi-Index Lenses

Contact lenses

Contact Lenses are covered once every *contract year* in lieu of eyeglasses. Additional coverage is provided for the cost of evaluation, materials, fitting and follow-up care.

You are eligible to select only one of either eyeglasses (eyeglass lenses and/ or eyeglass frames) or contact lenses. If you select more than one of these vision care services, we will pay benefits for only one vision care service.

Medically necessary Contact Lenses

Medically necessary and appropriate contact lenses in lieu of eyeglasses are covered. Contact lenses may be determined to be *medically necessary* in the treatment of the following conditions:

- Keratoconus,
- Pathological myopia,
- Aphakia,
- Anisometropia,
- Aniseikonia,
- Aniridia,
- Corneal disorders,
- Post-traumatic disorders, and
- Irregular astigmatism.
- *Medically necessary* contact lenses are dispensed in lieu of other eyewear.

Vision care services for members under age 21

Low Vision

Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and

provide training and instruction to maximize the remaining usable vision for our Members with low vision.

Covered low vision services include:

- One comprehensive low vision evaluation every 5 years, with a maximum charge of $300;
- Maximum low vision aid allowance of $600 with a lifetime maximum of $1,200 for items such as high-power spectacles, magnifiers and telescopes; and
- Follow-up care – four visits in any five-year period, with a maximum charge of $100 each visit.

Inpatient care

Hospital Services

Coverage is provided for unlimited days at general hospital or a specialty hospital and a maximum of 45 days per *contract year* for physical *rehabilitation*. *Covered services* include:

- Anesthesia
- Dialysis
- Intensive care/coronary care
- Physical, occupational, speech, and respiratory therapies
- *Semi-private* room (private room when *medically necessary*)
- Diagnostic tests and lab services
- Drugs
- Nursing care
- Radiation therapy
- Surgery; and
- *Provider*'s services while hospitalized

Reconstructive surgery and procedures and mastectomy surgeries

Coverage is provided for services required to relieve pain or to restore a bodily function impaired as a result of: a congenital defect; birth abnormality; traumatic injury; or covered surgical procedure.

The following services are covered in connection with a mastectomy, in accordance with Rhode Island General Law § 27-18-39:

- Surgical procedures known as a mastectomy;
- Axillary node dissection;

- Reconstruction of the breast affected by the mastectomy,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and treatment of physical complications of all stages of mastectomy (including lymphedema).

Inpatient care in hospital for mastectomies is covered for:

- A minimum of 48 hours following a surgical procedure known as a mastectomy; and
- A minimum of 24 hours following an axillary node dissection.

Any decision to shorten this minimum coverage shall be made by the attending physician in consultation with and upon agreement by the *member*. If the *member* agrees to an early discharge, coverage shall also include a minimum of one home visit conducted by a physician or registered nurse.

Breast prostheses are covered as described under orthoses and prosthetic devices.

Removal of a breast implant is covered when:

- The implant was placed post-mastectomy;
- There is documented rupture of a silicone implant; or
- There is documented evidence of autoimmune disease.

No coverage is provided for the removal of ruptured or intact saline breast implants or intact silicone breast implants except as specified above.

Cosmetic surgery is not covered.

Skilled Care in a Nursing Facility

Care in a *Skilled Nursing Facility* is covered if:

- Your condition needs *skilled* nursing services, *skilled rehabilitation* services or *skilled* nursing observation;
- The services are required on a daily basis; and

- This care can be provided only in a *Skilled Nursing Facility*.

Solid organ and hematopoietic stem cell transplants

Solid organ transplants and hematopoietic stem cell transplants which are generally accepted in the medical community for Members who are the solid organ or stem cell recipients. When the recipient is a *member*, the following services related to the procurement of the stem cells or solid organ from the donor are covered, but only to the extent that such services are not covered by any other plan of health benefits or health care coverage:

- Evaluation and preparation of the donor;
- Surgical intervention and recovery services related directly to donating the stem cells or solid organ to the *member*;
- A *member*'s donor search expenses for donors related by blood;
- The *member*'s donor search expenses for up to 10 searches for donors not related by blood; and
- A *member*'s human leukocyte antigen (HLA) testing.

We do not cover donor *charges* for Members who donate stem cells or solid organs to non-Members.

Maternity care

Maternity care (Outpatient)

Prenatal care, exams, and tests and postpartum care provided in a physician's office are covered.

In accordance with the ACA, laboratory tests associated with routine maternity care are covered in full.

Maternity care (*Inpatient*)

Hospital and delivery services and newborn in hospital child care are covered.

Coverage includes the services of licensed midwives for services within the licensed midwives' area of professional competence as defined by Rhode Island regulations Section

§23-13-9 and are currently reimbursed when rendered by any other licensed health care *provider*. Payment for licensed midwives will be made for services provided in a licensed health care facility and in accordance with department of health rules and regulations.

Coverage includes *inpatient* care in hospital for mother and newborn *child* for at least 48 hours following a vaginal delivery and 96 hours following a caesarean delivery.

The attending health care *provider* will make any decision to shorten the minimum coverage. In addition, this decision must be in consultation with the mother. The decision must be in accordance with the standards for guidelines for perinatal care published by the American College of Obstetrics and Gynecology and the American Academy of Pediatrics.

In the case of early discharge, covered post-delivery care will include home visits, parent education, assistance and training in breast or bottle-feeding and the performance of any necessary and appropriate clinical tests or any other tests or services consistent with the guidelines in this subsection.

The newborn *child*'s coverage consists of coverage of injury or sickness. This coverage includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, as well as routine well-baby care services.

Coverage of the new-born *child* will continue for 31 days after birth. For coverage to continue beyond this 31-day period, you must enroll the *child*.

Behavioral Health Services for Mental Health Care

Neighborhood provides mental health and substance abuse treatment *covered services* in parity with all other *covered services*. This means that there are no *benefit limits* on mental health and substance abuse treatment services and that these services have no different *cost sharing* than any other *covered service.*

Outpatient mental health care services

Services to diagnose and treat mental disorders in an *outpatient* setting are covered including:

- Individual, group and family therapies;
- Intensive *outpatient* programs;
- Enhanced Outpatient Services; and

- Medication management.

Medically necessary services meeting standard medical management protocols and within the benefit limits are covered. This coverage includes the services of counselors licensed in mental health and therapists licensed in marriage and family practice, excluding marital and family therapy unless the individual is diagnosed with a mental disorder.

Psychopharmacological services and neuropsychological assessment services are covered as *outpatient* medical care.

Inpatient and intermediate mental health care services

Inpatient mental health services for mental disorders in a general hospital, a mental health hospital, or a *chemical dependency* facility are covered.

Intermediate mental health care services are covered. These services are more intensive than traditional community-based *outpatient* mental health care services. They are less intensive than 24-hour hospitalization. Some examples of covered intermediate mental health care services are:

- Acute/Crisis stabilization unit;
- Partial hospital programs;
- Day/Evening Treatment; and
- Acute residential treatment (longer term residential treatment is not covered).); and adult intensive services (AIS).

AIS is a facility-based mental health care program. Adult intensive services are primarily based in the home for qualifying adults with moderate to severe psychiatric conditions. This program must consist of, but is not limited to, the following:

- Ongoing emergency or crisis evaluations 24 hours a day 7 days per week;
- Psychiatric assessment;
- Medication evaluation and management;
- Case management;
- Psychiatric nursing services; and

- Individual, group, and family therapy.

Under this AIS program, a *provider* must provide a minimum of six contact hours per week.

No visit limit applies to *inpatient* or intermediate mental health care services.

Behavioral Health Services for Chemical Dependency

Neighborhood provides mental health and substance abuse treatment *covered services* in parity with all other *covered services*. This means that there are no *benefit limits* on mental health and substance abuse treatment services and that these services have no different *cost sharing* than any other *covered service.*

Outpatient chemical dependency services

Outpatient chemical dependency treatment services are covered. Methadone maintenance or methadone treatment related to chemical dependency disorders are covered.

Treatment for the abuse of tobacco or caffeine is not covered under these *chemical dependency* services benefits.

Inpatient and Intermediate chemical dependency services

Inpatient detoxification and treatment services in a general hospital, *chemical dependency* facility, or community residence is covered.

Intermediate *chemical dependency* services are more intensive than traditional community-based *outpatient chemical dependency* services. They are less intensive than 24-hour hospitalization. Some examples of covered intermediate *chemical dependency* services are:

- Partial hospital programs;
- Day/Evening treatment;
- Intensive Outpatient program; and
- Enhanced Outpatient program, intensive *outpatient* programs.

Intermediate *chemical dependency* services include adult intensive services (AIS).

AIS is a facility-based *chemical dependency* program. Adult intensive services are primarily based in the home for qualifying adults with moderate to severe *chemical dependency* conditions. This program must consist of, but is not limited to, the following:

- Ongoing *emergency* or crisis evaluations available 24 hours a day 7 days per week;
- Psychiatric and addiction assessment;
- Medication evaluation and management;
- Case management;
- Addiction nursing services; and
- Individual, group, and family therapy.

Under this AIS program, a *provider* must provide a minimum of six contact hours per week.

Other health services

Ambulance services

Ground, sea, and air ambulance transportation for *emergency* care is covered. If you refuse to be transported to the hospital or other medical facility you will be responsible for the costs of this treatment.

Non-emergency ambulance transportation for *medically necessary* care is covered when the member's medical condition prevents safe transportation by any other means.

Clinical trials

Coverage is provided for individuals participating in approved clinical trials.

- An approved clinical trial means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or a life-threatening disease or condition and is described in any of the following:
- The study or investigation is approved or funded, which may include funding through in-kind contributions, by one or more of the following:
    - The federal National Institutes of Health;

- The federal Centers for Disease Control and Prevention;
- The federal Agency for Health Care Research and Quality;
- The federal Centers for Medicare & Medicaid Services;
- A cooperative group or center of any of the entities described above or the U.S. Department of Defense or the U.S. Department of Veterans' Affairs;
- A qualified non-governmental research entity identified in the guidelines issued by the federal National Institutes of Health for center support grants; or
- A study or investigation conducted by the U.S. Department of Veterans' Affairs, the U.S. Department of Defense, or the U.S. Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of U.S. Department of Health and Human Services determines:
  - Is comparable to the system of peer review of studies and investigations used by the Federal National Institutes of Health; and
  - Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration; or
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Neighborhood will not:

- Deny a qualified *member* participation in an approved clinical trial;
- Deny or limit or impose additional conditions on the coverage of items and services furnished in connection with participation in the approved clinical trial; and
- Discriminate against the *member* on the basis of the *member*'s participation in the approved clinical trial.

Durable Medical Equipment

Equipment must meet the following definition of "*Durable Medical Equipment.*"

Durable Medical Equipment is a device or instrument of a durable nature that:

- Is reasonable and necessary to sustain a minimum threshold of independent daily living;
- Is made primarily to serve a medical purpose;
- Is not useful in the absence of illness or injury;
- Can withstand repeated use;
- Can be used in the home.

In order to be eligible for coverage, the equipment must also be the most appropriate available supply or level of service for the *member* in question considering potential benefits and harms to that individual. Neighborhood determines this.

Neighborhood may decide that equipment is: (1) non-medical in nature; and (2) used primarily for non-medical purposes. This may occur even though that equipment has some limited medical use. In this case, the equipment will not be considered *Durable Medical Equipment* and will not be covered under this benefit.

Hearing aids

Coverage is $1,500 per individual hearing aid, per ear, every three (3) years for anyone under the age of 19 years, and $700 per individual hearing aid per ear, every three (3) years for anyone of the age of 19 years and older, in accordance with Rhode Island General Law § 27-41-63.

Home health care

Covered home health care is a *medically necessary* program to reduce the length of a hospital stay or to delay or eliminate an otherwise *medically necessary* hospital admission. Coverage includes:

- Home visits by a physician;
- *Skilled* nursing care and physical therapy;
- Speech therapy;
- Occupational therapy;

- Medical/ psychiatric social work;
- Nutritional consultation;
- Prescription drugs and medication;
- Medical and surgical supplies (Examples include dressings, bandages and casts.);
- Laboratory tests, x-rays, and E.K.G. and E.E.G. evaluations;
- The use of *Durable Medical Equipment*, and
- The services of a part-time *home health aide*.

Hospice care services

We will cover the following services for Members who are terminally ill. Terminally ill means having a life expectancy of 6 months or less:

- Physician services;
- Nursing care provided by or supervised by a registered professional nurse;
- Social work services;
- Volunteer services; and
- Counseling services (This includes bereavement counseling services for the *member*'s family for up to one year after the *member*'s death).

Hospice services can be provided in a home setting, on an *outpatient* basis; and on a short-term *inpatient* basis, for the control of pain and management of acute and severe clinical problems which cannot, for medical reasons, be managed in a home setting.

Injectable, infused or inhaled medications

Coverage is provided for injectable, infused or inhaled medications that are:

- Required for and an essential part of an office visit to diagnose and treat illness or injury; or
- Received at home with drug administration services by a home infusion *provider*.

Medications may include, but are not limited to, total parenteral nutrition therapy, chemotherapy, and antibiotics. Coverage includes the components required to administer these medications. This includes, but is not limited to, *Durable Medical Equipment*, supplies, pharmacy compounding, and delivery of drugs and supplies.

There are designated home infusion *provider*s for a select number of specialized pharmacy products and drug administration services. These *provider*s offer clinical management of drug therapies, nursing support, and care coordination to Members with acute and chronic conditions. Medications offered by these *provider*s include, but are not limited to, medications used in the treatment of hemophilia, pulmonary arterial hypertension, immune deficiency, and enzyme replacement therapy.

Medications listed on our web site as covered under a Neighborhood pharmacy benefit are not covered under this "Injectable, infused, or inhaled medications" benefit.

Medical supplies

We cover the cost of certain types of medical supplies including ostomy, tracheostomy, catheter, and oxygen supplies; and insulin pumps and related supplies.

New Cancer Therapies for cancer or other life-threatening diseases or conditions

Coverage is provided for both *inpatient* and *outpatient* new cancer therapies still under investigation as required by Rhode Island General Laws Section § 27-18-36.

To the extent required by Rhode Island and federal law, new therapies provided as part of an approved clinical trial conducted to prevent, detect, or treat cancer or other life-threatening diseases or conditions are covered to the same extent as those services would be covered if the *member* did not receive care in an approved clinical trial.

Orthoses and prosthetic devices

We cover the cost of orthoses and prosthetic devices, including repairs, as required by Rhode Island law. This includes breast prostheses as required by federal law.

Coverage is provided for the most appropriate model that adequately meets the *member*'s needs. His or her treating *provider* determines this.

The scalp hair prosthesis or wig benefit is limited to the *maximum benefit* of $350 per member per *contract year* when worn for hair loss suffered as a result of cancer treatment in accordance with Rhode Island General Law 26-18-68.

Special medical formulas

Coverage includes low protein foods when given to treat inherited diseases of amino acids and organic acids.

Nonprescription enteral formulas are covered for home use 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.

A *provider* must prescribe the formula or food for these treatments. Coverage shall not exceed an amount of two thousand five hundred dollars ($2,500) per covered member per year.

SECTION 3 Prescription drug benefits

Section 3.1 Your prescription drug benefits

Introduction

This section describes the prescription drug benefit. These topics are included here. They explain your prescription drug coverage:

- How Prescription Drugs Are Covered;
- Prescription Drug Coverage Table;
- Management; Programs;
- What is Covered;
- What is Not Covered;
- *Neighborhood* Pharmacy
- Filling Your Prescription.

How Prescription Drugs Are Covered

Neighborhood offers a complete list of covered drugs. This list of covered drugs is called our Formulary. See our website at www.nhpri.org. for a list of covered drugs on our Formulary. You can also call a Member Specialist. In addition , Drugs listed on our Formulary are covered only if they comply with the "Neighborhood Health Plan of Rhode Island (Neighborhood) Pharmacy Management Programs" section below and are:

- provided to treat an injury, illness, or pregnancy and

- *Medically Necessary*

The "Prescription Drug Coverage Table" below describes your prescription drug benefit amounts.

- Tier-1 Generic Drugs have the lowest] level *Cost Sharing Amount*; many generic drugs are on Tier-1.
- Tier-2 Preferred Brand Drugs have the middle] a higher] level *Cost Sharing Amount*.
- Tier-3 Non Preferred Brand Drugs have the higher] highest] level *Cost Sharing Amount*.]

ALL OTHER MEDICATIONS OBTAINED AT A RETAIL PHARMACY:
Covered prescription drugs include both acute and maintenance drugs. Prescription drugs covered up to a 30-day supply. You need to obtain these drugs directly from a Neighborhood designated retail pharmacy.

Tier-1 drugs:	**Tier-2 drugs:**	**Tier-3 drugs:**
$2-$10 Copayment	$4-$40 Copayment	$6-$60 Copayment
for a 1-30-day supply	for a 1-30-day supply	for a 1-30-day supply

- You always pay the applicable Cost Sharing Amount. This is the case even if the cost of the drug is less than the Cost Sharing Amount.
- Generic Incentive Program: Your Provider may prescribe a brand-name drug that has a generic equivalent. This can happen in Rhode Island and many other states. In this case, you will receive the generic drug and pay the applicable Tier Cost Sharing Amount.
- Wherever you fill your prescription, your Provider may request that you receive a covered brand-name drug only. In this case, you will pay the Cost Sharing Amount for the generic drug.
- You will also need to pay the difference between the cost of the generic drug and the cost of the covered brand-name drug. In many cases, there may be a significant difference in what you need to pay.

<u>Additional Coverage information related to drugs that are included on our Formulary</u>

We cover the following under this Prescription Drug Benefit when the drug or device is listed on our Formulary:

- Test strips for glucose monitors, insulin, insulin syringes, and oral agents for controlling blood sugar levels

- Specific Oral contraceptives, diaphragms, and other hormonal contraceptives (e.g., patches, rings) that by law require a prescription*

  *Note: This Prescription Drug Benefit only describes contraceptive coverage for oral contraceptives, diaphragms, and other hormonal contraceptives (e.g., patches, rings) that by law require a prescription. See "Family planning" above for information about other covered contraceptive drugs and devices.

- Fluoride for Children'

- Specific Injectables and biological serum Off-label use of FDA-approved prescription drugs used in the treatment of cancer which have not been approved by the FDA for that indication, provided, however, that such a drug is recognized for such treatment in one of the standard reference compendia, in the medical literature, or by the commissioner of insurance.

- Compounded medications are only covered if at least one active ingredient requires a prescription by law;

- Specific over-the-counter drugs at **www.nhpri.org**.

- Specific prescription and over-the-counter smoking cessation agents that are recommended and prescribed by a Neighborhood Plan *provider*'; this benefit is subject to prior authorization.

Certain prescription drug products may be subject to a Neighborhood Pharmacy Management Program described below.

Section 3.2 Pharmacy management programs

In order to provide safe, clinically appropriate, cost-effective medications under this Prescription Drug Benefit, we have developed the following Pharmacy Management Programs.

Quantity Limitations Program

We limit the quantity of selected medications Members can receive in a given time period. We do this for cost, safety, and/or clinical reasons.

Prior Authorization Program

We restrict the coverage of certain drug products. These are drugs with a narrow indication for usage, may have safety concerns, and/or are extremely expensive. We require the prescribing *provider* to obtain prior approval from us for such drugs.

Step therapy is a type of prior authorization program. This program uses a step-wise approach. It requires the use of the most therapeutically appropriate and cost-effective agents first. After that, other medications may be covered. You must try one or more medications on a lower step to treat a certain medical condition first. After that, we may cover a medication on a higher step for that condition.

Non-Covered Drugs:

A small number of drugs are not covered. Typical drugs not covered include

- Drugs and/or drug therapies for cosmetic purposes including but not limited to treatment of facial wrinkles; "fungal" nails not confirmed by laboratory results; hair restoration (except as an adjunct to chemotherapy; hair removal; vitiligo.
- Drugs and/or drug therapies used for the treatment of erectile dysfunction
- Experimental drugs and/or drug therapies
- Drugs and/or drug therapies used for the treatment of infertility
- Drugs used to terminate pregnancies.

New-To-Market Drug Evaluation Process

Neighborhood Pharmacy and Therapeutics Committee reviews new-to-market drug products for safety, clinical effectiveness and cost. The review is generally completed within the 6 month period following the marketing launch of the drug. We then make a coverage determination based on the Pharmacy and Therapeutics Committee's recommendation.

Drugs that have not yet been reviewed and approved by the Neighborhood Pharmacy and Therapeutics Committee are subject to our prior authorization policy and may not be covered.

Important Notes:

- Your *provider* may feel it is *medically necessary* for you to take medications that are not on the formulary or restricted under any of the "Neighborhood Pharmacy Management Programs" above. In this case, he or she may submit a request for coverage. We will approve the request if it meets our guidelines for coverage. For more information, call a *Member Services* representative.

- You may have questions about your prescription drug benefit. You may want to know the tier of a particular drug. You might like to know if your medication is part of a Pharmacy Management Program. For these issues, check our Web site at www.nhpri.org. You can also call a *Member Services* representative at 855-321-XCHG (855-321-9244)

- Where to Fill Prescriptions:

Fill your prescriptions at a Neighborhood designated pharmacy. Neighborhood designated pharmacies include:

- For the majority of prescriptions, most of the pharmacies in Rhode Island. They also include additional pharmacies nationwide.

How to Fill Prescriptions:

- When you fill a prescription, provide your Member ID to any Neighborhood designated pharmacy, and pay your *cost sharing* amount.

- The cost of your prescription may be less than your Copayment. In this case, you only need to pay the actual cost of the prescription.

- If you have any problems using this benefit at a Neighborhood designated pharmacy, call the *Member Services* Department.

Important: Only at Neighborhood designated pharmacies will honor your prescription drug benefit. In cases where you obtained drugs from a pharmacy other than a Neighborhood pharmacy due to an *emergency*, call *Member Services*. They can explain how to submit your prescription drug *claim*s for reimbursement.

SECTION 4 Benefits not covered by the plan

Section 4.1 Benefits we do not cover (exclusions)

This section tells you what kinds of benefits are "excluded." The term "excluded" means that the plan does not cover these benefits.

The list below describes some services and items that are not covered under any conditions and some that are excluded only under specific conditions.

If you get benefits that are excluded, you must pay for them yourself. We will not pay for the excluded benefits listed in this section (or elsewhere in this *Certificate*). The only exception:

If a benefit on the exclusion list is found upon *appeal* to be a benefit that we should have paid for or covered because of your specific situation.

Not *Medically necessary*.

A service, supply or drug that is not *medically necessary*. *Medically necessary* health care services are those services, supplies or medications provided for the purpose of preventing, evaluating, diagnosing or treating an injury, illness, or pregnancy, and which are all of the following.

- In accordance with generally accepted standards of medical practice. Generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your injury, illness, or pregnancy.
- Not more costly than an alternative, service, supply or medication that is at least as likely to produce equal results as to the diagnosis or treatment of your injury, illness, or pregnancy.
- Not primarily for your, or another person's personal comfort or convenience.

Coverage for *Medically necessary preventive care* is governed by terms of this *Certificate*.

Not a Covered Service.

Health services and supplies that do not meet the definition of a Covered Service which are services, supplies, or medications which we determine are all of the following:

- *Medically necessary*.
- Described as a Covered Service in this *Certificate*.
- Not otherwise excluded in this *Certificate*.

Facility *charges* or related services if the procedure being performed is not a Covered Service, except as provided elsewhere in this *Certificate*.

Services provided outside the United States.

Any service, supply, or medication that is obtained outside of the 50 United States is not covered. The only exceptions to this rule are for *emergency* care services or urgent care services while traveling.

Custodial Care

Custodial care, rest care, day care, or non-*skilled* care in any facility is not covered, including care in convalescent homes, nursing homes, homes for the aged, halfway houses, or other residential facilities. *Custodial care* services include, but are not limited to:

- Any homemaking, companion, or chronic (custodial) care services;
- The services of a personal care attendant;
- *Charges* for private duty nursing when primary duties are limited to bathing, feeding, exercising, homemaking, giving oral prescription drugs or acting as a companion.

A service, supply, or medication that is experimental or investigational

We will not pay for any related treatments provided to the *member* for the purpose of furnishing the *experimental* or *investigative* treatment. The fact that an *experimental* or investigational service, supply or drug is the only available treatment for a particular condition will not result in benefits for that condition. This exclusion does not apply to services which meet coverage requirements under Rhode Island and federal law for:

- Treatment of chronic Lyme disease;
- New therapies conducted to prevent, detect, or treat cancer or other life-threatening diseases or conditions; or
- Off-label uses of prescription drugs for the treatment of cancer.

Services provided by the relatives of a *member*

Services provided by a relative who is not a *provider* are not covered. If the relative is a *provider*, services provided by an immediate family member (by blood or marriage) are not covered.

If you are a *provider*, you cannot provide or authorize services for yourself or a member of your immediate family (by blood or marriage).

Services covered by other entities or services that would otherwise not be covered

The following services, supplies, or drugs are not covered:

- Services, supplies, or medications required by a third party which are not otherwise *medically necessary*. Examples of a third party are an employer, an insurance company, a school, or a court.
- Services for which you are not legally obligated to pay. Services for which no charge would be made if you had no health plan.
- Care for conditions for which benefits are covered under Federal, State or Local legislation such as workers' compensation or no fault auto insurance, or other government programs other than Medicaid.
- Care for conditions that state or local law requires to be treated in a public facility.
- Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
- Health services while on active military duty.
- Any additional fee a *provider* may charge as a condition of access or any amenities that access fee is represented to cover.

Personal Care, Comfort or Convenience Items

Charges incurred when the *member*, for his or her convenience, chooses to remain an *inpatient* beyond the discharge hour.

Supplies, equipment and similar services and supplies primarily for personal comfort are not covered.

Incidental services such as television, telephone and beauty/ barber service or guest service are not covered.

Dental Care Services

The following dental care services, treatments, and supplies are excluded:

- Preventive dental care not described in this *Certificate* as covered;

- Dental supplies;
- Dentures;
- Skeletal jaw surgery, except as provided under "Oral health services" earlier in this *Certificate*;
- Alteration of teeth;
- Care related to deciduous (baby) teeth;
- Splints and oral appliances (except those described in this *Certificate* as covered), including those for temporomandibular joint (TMJ) disorders. TMJ disorder- related therapies, including TMJ appliances, occlusal adjustment, or TMJ appliance-related therapies, are not covered.

Cosmetic Services

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

Except *covered services* described in this *Certificate*, services, supplies or medications to change or improve appearance are not covered. This includes, but is not limited to:

- Excision of excess skin or subcutaneous tissue including brachioplasty (arm lift) or abdominoplasty (tummy tuck) (except Panniculectomy as described in this *Certificate*);
- Cervicoplasty (Plastic surgery on the neck or on the cervix of the uterus);
- Laser treatment for acne and acne scars;
- Chemical exfoliations, peels, abrasions (or dermabrasions or planing for acne, scarring, wrinkling, sun damage or other conditions);
- Correction of variations in normal anatomy including augmentation mammoplasty, mastopexy, and correction of congenital breast asymmetry (modifying the size, contour, and elevation of breasts);
- Gynecomastia surgery, including but not limited to mastectomy and reduction mammoplasty;

- Genioplasty (reduction and addition of material to the chin);
- Hair transplants;
- Hair removal (including electrolysis epilation);
- Inverted nipple surgery;
- Osteoplasty (facial bone reduction);
- Otoplasty (ear plastic surgery);
- Repeated cauterizations or electrofulguration methods used to remove growths on the skin;
- Rhinoplasty (nose plastic surgery);
- Rhytidectomy (facelift);
- Scar Revision, regardless of symptoms;
- Sclerotherapy/ treatment for spider veins;
- Subcutaneous injection of filling material;
- Liposuction/ suction assisted lipectomy (remove fatty deposits in the thighs, neck, arms, and stomach);
- Tattooing or Tattoo Removal (except tattooing of the nipple/areola related to a mastectomy);
- Testicular prosthesis surgery;
- Removal or destruction of skin tags;
- Treatment of vitiligo (white patches on your skin);
- Scalp hair prostheses made specifically for an individual, or a wig, and provided for hair loss due to alopecia areata, alopecia totalis, or permanent loss of scalp hair due to injury.

Medications and other products which can be purchased over-the- counter except those listed as covered and listed on our Formulary on our website at www.nhpri.org.

Laboratory tests ordered by a *member* are not covered even if they are performed at a licensed laboratory.

Pregnancy terminations.

Costs associated with home births; costs associated with the services provided by a doula.

Circumcision performed in any setting other than a hospital, Day Surgery, or a physician's office.

Infertility services

Infertility treatment is not covered for:

- Members who do not meet the definition of Infertility;
- *Experimental* infertility procedures;
- The costs of surrogacy*;
- Long-term (longer than 90 days) sperm or embryo cryopreservation unless the *member* is in active infertility treatment;
- Costs associated with donor recruitment and compensation;
- Infertility services which are necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization; and
- Donor sperm and associated laboratory services in the absence of diagnosed male factor infertility in the partner.
- Drugs for anonymous or designated egg donors that are directly related to a stimulated Assisted Reproductive Technology (ART) cycle, unless the *member* is the sole recipient of the donor's eggs. Prior authorization is recommended for these services.

*the costs of surrogacy means:

- (1) All costs incurred by a fertile woman to achieve a pregnancy as a surrogate or gestational carrier for an infertile *member*. These costs include, but are not limited to: costs for drugs needed for implantation, embryo transfer, and cryopreservation of embryos;
- (2) Use of donor egg and a gestational carrier; and
- (3) Costs for maternity care if the surrogate is not a *member*.
- A surrogate is a person who carries and delivers a *child* for another either through artificial insemination or surgical implantation of an embryo.
- A gestational carrier is a surrogate with no biological connection to the embryo/*child*.

- Note: We may authorize short-term (less than 90 days) cryopreservation of sperm or embryos for certain medical conditions that may impact a *member*'s future fertility. Prior authorization is recommended for these services.

Treatments, medications, procedures, services and supplies related to: medical or surgical procedures for sexual reassignment; reversal of voluntary sterilization; or over-the-counter contraceptive agents.

Human organ transplants, except as described in this Certificate as covered.

The purchase of an electric hospital grade breast pump

Services provided to a non-*member*, except as described in this Certificate for:

- Organ donor *charges* under "Human organ transplants";
- Bereavement counseling services under "Hospice care services"; and
- The costs of procurement and processing of donor sperm, eggs, or inseminated eggs, or banking of donor sperm or inseminated eggs, under "Infertilityservices." (This is to the extent such costs are not covered by the donor's health coverage, if any.)

Alternative, holistic, naturopathic, and/or functional health medicine services

- All alternative, holistic, naturopathic, and/or functional health medicine services, supplies or procedures are not covered.

- All services, procedures, labs and supplements associated with this type of medicine are not covered.

Services, programs, supplies, or procedures performed in a non-conventional setting

This includes, but is not limited to, spas/resorts, educational, vocational, or recreational settings, Outward Bound, or wilderness, camp or ranch programs.

This is the case even if the services, programs, supplies or procedures are performed or provided by licensed *provider*s, such as mental health professionals, nutritionists, nurses or physicians. Some examples of services that may be excluded if they are performed in a non-conventional setting are psychotherapy, ABA services, and nutritional counseling.

Blood and Blood Related Services

Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking and blood products, except as below.

Note: The following blood services and products are covered:

- Blood processing;
- Blood administration;
- Factor products (monoclonal and recombinant) for Factor VIII deficiency (classic hemophilia), Factor IX deficiency (Christmas factor deficiency), and von Willebrand disease (prior authorization is recommended for these services);
- Intravenous immunoglobulin for treatment of severe immune disorders, certain neurological conditions, infectious conditions, and bleeding disorders (prior authorization is recommended for these services).

Devices and procedures intended to reduce snoring.

Exclusions include, but are not limited to, laser- assisted uvulopalatoplasty, somnoplasty, and snore guards.

Examinations, evaluations or services for educational or developmental purposes

Exclusions include:

- Physical therapy, speech therapy, and occupational therapy, except those described as covered in this *Certificate*.

- Vocational *rehabilitation* services and vocational retraining.

- Services to treat learning disabilities, behavioral problems, and developmental delays and services to treat speech, hearing and language disorders in a school-based setting.

The term "developmental" refers to a delay in the expected achievement of age-appropriate fine motor, gross motor, social, or language milestones not caused by an underlying medical illness or condition.

Eyeglasses, lenses, or frames

Except as described in this *Certificate* as covered, exclusions include refractive eye surgery (including radial keratotomy) for conditions that can be corrected by means other than surgery, contact lenses, or contact lens fittings.

Prescription Drug Benefit:

- Prescription and over-the-counter homeopathic medications.

- Over the counter drugs that by law do not require a prescription except those that are included on our Formulary

- Drugs not listed on the "Neighborhood Formulary". See the list at **www.nhpri.org**. Also, you can call *Member Services* for more information.

- Vitamins and dietary supplements (except prescription prenatal vitamins and fluoride for Children and supplements for the treatment of mitochondrial disease that are included on our Formualry]).

- Topical and oral fluorides for adults.

- Cervical caps, IUDs, implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants), Depo-Provera or its generic equivalent. Although not covered under the prescription drug benefit, these are covered under your *outpatient* care benefit earlier in this chapter. Oral contraceptives, diaphragms and other hormonal contraceptives (e.g., patches, rings) that by law require a prescription are covered under the prescription benefit.

- *Experimental* drugs: drugs that cannot be marketed lawfully without the approval of the FDA and such approval has not been granted at the time of their use or proposed use or such approval has been withdrawn.
- Non-drug products such as therapeutic or other prosthetic devices, appliances, supports, or other non-medical products. These may be provided as described earlier in this chapter.
- Prescriptions filled at pharmacies other than Neighborhood designated pharmacies, except for *emergency* care.
- Drugs dispensed in an amount or dosage that exceeds our established quantity limitations.
- Compounded medications, if no active ingredients require a prescription by law.
- Prescription medications once the same active ingredient or a modified version of an active ingredient that is therapeutically equivalent to a covered prescription medications becomes available over-the-counter. In this case, the specific medication may not be covered. Also, the entire class of prescription medications may also not be covered. For more information, call *Member Services*. You can also check our Web site at **www.nhpri.org**.
- Prescription medications when packaged with non-prescription products.
- Drugs for the treatment of erectile dysfunction.

Pediatric vision care services, treatments and supplies

Pediatric vision care services exclude:

- Services and materials not meeting accepted standards of optometric practice.
- Special lens designs or coatings other than those described as *covered services*.
- Replacement of lost or stolen eyewear.
- Non-prescription (Plano) lenses.
- Two pairs of eyeglasses in lieu of bifocals.
- Insurance of contact lenses.

Routine foot care

Routine foot care is not a covered service including the treatment of corns, calluses, the trimming of nails, cutting, or debriding, treatment of flat feet or subluxation of the foot; the treatment of simple ingrown nails and other preventive hygienic procedures, orthopedic shoes and related items that are not part of a brace; or other support devices for the feet.

Note: This exclusion does not apply to routine foot care for Members diagnosed with diabetes.

Transportation

Exclusions include, but are not limited to transportation by chair car, wheelchair van, or taxi, except as described in "Ambulance services" in this *Certificate*.

Lodging

Lodging is not covered even when related to receiving any medical service.

Devices, Appliances and Prosthetics138

Non-covered services include, but are not limited to:

- Devices used specifically as safety items or to affect performance in sports-related activities.
- Orthotic appliances that straighten or re-shape a body part such as foot orthotics and cranial banding.
- Some types of braces, including over-the-counter orthotic braces.

Other Services

- Acupuncture; biofeedback, except for the treatment of urinary incontinence;
- Hypnotherapy;
- Psychoanalysis;
- TENS units or other neuromuscular stimulators and related supplies;
- Electrolysis;

- Spinal manipulation;
- *Inpatient* and *outpatient* weight-loss programs and clinics;
- Nutritional counseling, except as described in this *Certificate*;
- Relaxation therapies; massage therapies, except as described under "Short-term speech, physical, and occupational therapy services" in this *Certificate*;
- Services by a personal trainer;
- Exercise classes;
- Cognitive *rehabilitation* programs;
- Cognitive retraining programs.
- Also excluded are diagnostic services related to any of these procedures or programs.

Pediatric Dental Services

- Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible *covered services* provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;
- Those which are for specialized procedures and techniques;
- Those performed by a dentist who is compensated by a facility for similar *covered services* performed for Members;
- Duplicate, provisional and temporary devices, appliances and services;
- Plaque control programs, oral hygiene instruction and dietary instructions;
- Services to alter vertical dimension and/ or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth *rehabilitation* and restoration for misalignment of teeth;
- Gold foil restorations;

- *Charges* by the *provider* for completing dental forms;
- Adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;
- Use of material or *home health aide*s to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
- Sealants for teeth other than permanent molars;
- Precision attachments, personalization, precious metal bases and other specialized techniques;
- Replacement of dentures that have been lost, stolen or misplaced;
- Repair of damaged orthodontic appliances;
- Replacement of lost or missing appliances;
- Fabrication of athletic mouth guard;
- Internal bleaching;
- Nitrous oxide;
- Oral sedation;
- Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection.

Non-Medical Services

- Any *charges* for failure to keep a scheduled appointment;
- Services or treatment provided as a result of intentionally self-inflicted injury or illness;
- Office infection control charges;
- *Charges* for copies of your records, charts or X-rays, or any costs associated with forwarding/mailing copies of your records, charts or X-rays;
- State or territorial taxes on services performed;

The plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.

Chapter 5. Asking us to pay our share of a bill you received for covered medical services

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services

Section 1.1 If you pay our plan's share of the cost of your covered services, or if you receive a bill, you can ask us for payment

We pay *network provider*s directly for *covered services*. However, occasionally, you may receive a bill from a *provider* for *covered services*

Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services that are covered by our plan.

There may also be times when you get a bill from a *provider* for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the *provider* directly.

Our payments to you or the *provider* fulfill our responsibility under this agreement. Your benefits are personal to you and cannot be assigned, in whole or in part, to another person or organization. We reserve the right to be reimbursed by the Member for payments made due to our error.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

1. When you've received *emergency* or urgently needed medical care from a *provider* who is not in our plan's network

   You can receive *emergency* services from any *provider*, whether or not the *provider* is a part of our network. When you receive *emergency* or urgently needed care from a *provider* who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the *provider* to bill the plan for our share of the cost.

   - If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.

- At times you may get a bill from the *provider* asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
    - If the *provider* is owed anything, we will pay the *provider* directly.
    - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

2. When a *network provider* sends you a bill you think you should not pay

Network *provider*s should always bill the plan directly, and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share.

- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow *provider*s to add additional separate charges, called "*balance billing*." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the *provider* less than the *provider charges* for a service and even if there is a dispute and we don't pay certain *provider* charges.
- Whenever you get a bill from a *network provider* that you think is more than you should pay, send us the bill. We will contact the *provider* directly and resolve the billing problem.
- If you have already paid a bill to a *network provider*, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. When you obtain a prescription at a non-designated pharmacy

- If you need to obtain a prescription at a non-designated pharmacy, you will need to pay for the prescription up front and submit a claim for reimbursement.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can *appeal* our decision. Chapter 7 of this booklet (What to do if you have a problem or complaint (coverage decisions, *appeal*s, *complaint*s) has information about how to make an *appeal*.

SECTION 2 How to ask us to pay you back or to pay a bill you have received

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

Send us an itemized bill along with the following:

- *Subscriber*'s name and address;
- Your member identification number;
- Patient's name and age;
- 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 statement that indicates either that you are or you are not enrolled for coverage under any other health insurance plan and program. If you are enrolled for other coverage, you must include the name of the other carrier(s).

Mail your request for payment together with any bills or receipts to us at this address:

Member Services
Neighborhood Health Plan of Rhode Island
299 Promenade Street
Providence, Rhode Island 02908

Note: You must contact us regarding your bill(s) or send your bill(s) to us within 90 days from the date of the covered service, or as soon as reasonably possible. If you do not, the bill cannot be considered for payment, unless you are legally incapacitated. In no event, except in cases of legal incapacitation, can bills be considered for payment after a period of 1 year.

If you receive *covered services* from a non-Neighborhood Plan *provider*, we will pay up to the Reasonable Charge for the services within 60 days of receiving a completed Member Reimbursement Medical *Claim* Form and all required supporting documents.;

Contact *Member Services* if you have any questions. If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the service and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care is covered and you followed all the rules for getting the care, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the *provider*. (Chapter 3 explains the rules you need to follow for getting your medical services covered.)

- If we decide that the medical care is not covered, or you did not follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to *appeal* that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an *appeal*. If you make an *appeal*, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this *appeal*, go to Chapter 7 of this booklet (What to do if you have a problem or complaint (coverage decisions, *appeal*s, *complaint*s). The *appeal*s process is a formal process with detailed procedures and important deadlines.

Chapter 6. Your rights and responsibilities

SECTION 1 Our plan must honor your rights as a member of the plan

Section 1.1 Your Rights as a member

We support your rights as a member of Neighborhood and want to work with you to be sure that you receive the highest quality health care and services that you deserve. Please read your rights and responsibilities as a member of Neighborhood carefully:

- You have the right to receive information about Neighborhood, its services, *provider*s and *provider*s, and Members' rights and responsibilities.
- You have the right to be treated with respect and recognition of your dignity and right to privacy.
- You have the right to participate with your practitioners in decision-making regarding your health care.
- You have the right to privacy of all records and communications to the extent required by law. (Neighborhood employees follow a strict confidentiality policy regarding all member information.)
- You have the right to respectful, personal attention without regard to your race, national origin, gender, age, sexual orientation, religious affiliation, or preexisting conditions.
- You have the right to obtain a second medical opinion for medical and surgical concerns.
- You have the right to a candid discussion of appropriate or *medically necessary* treatment options for your conditions, regardless of cost or benefit coverage.
- You have the right to voice complaints or *appeal*s about Neighborhood or the care provided by its *provider*s.
- You have the right to make recommendations about Neighborhood's Member Rights and Responsibilities policies.

To get information from us in a way that works for you, please call *Member Services*.

Our plan has people and free language interpreter services available to answer questions from non-English speaking Members. We can also give you information in Braille, in large print, or other alternate formats if you need it.

Section 1.2 You have the right to receive information about Neighborhood, its services, network of providers, and Members' Rights and Responsibilities

As a member of Neighborhood Exchange Health Plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call *Member Services*.

- Information about our *network provider*s.
    - You have the right to get information from us about the qualifications of the *provider*s in our network and how we pay the *provider*s in our network.
    - For a list of the *provider*s in the plan's network, see the *Provider* Directory.
    - For more detailed information about our *provider*s, you can call *Member Services* or visit our website at www.nhpri.org.
- Information about your coverage and rules you must follow in using your coverage.
    - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
    - If you have questions about the rules or restrictions, please call *Member Services*.
- Information about why something is not covered and what you can do about it.
    - If a medical service is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service from an *out-of-network provider*.
    - If you are not happy or if you disagree with a decision we make about what medical care is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an *appeal*. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an *appeal* if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)

- If you want to ask our plan to pay our share of a bill you have received for medical care, see Chapter 5 of this booklet.

Section 1.3 You have the right to be treated with respect and recognition of your dignity and right to privacy

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, *claim*s experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at *Member Services*. If you have a complaint, such as a problem with wheelchair access, *Member Services* can help.

Section 1.4 You have the right to participate with your providers in decision making regarding your health care

You have the right to make decisions about your health care. You can refuse treatment or procedures anytime you wish. But one day, you may be unable to make or voice your decisions. These documents help make your wishes known:

- A living will is a set of instructions. It says what should happen if you become seriously ill and are unable to communicate.
- Durable power of attorney lets another person make health care decisions for you. You choose who this person will be. It could be your spouse, a family member, or a friend.
- Advance directives explain the treatment you want if you become seriously ill or injured. Advance directives can be written or spoken.

Ask your *Primary Care Provider* (*PCP*) about these options. You also can find related forms at the Rhode Island Department of Health website:

http://www.health.ri.gov/lifestages/death/about/livingwill/

Section 1.5 You have the right to privacy of all records and communications to the extent required by law

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.

- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

Please review the information below very carefully:

This information describes how health information about you may be used and shared and how you can get this information.

When does Neighborhood share my health information with others?

We share your health information with others, without your approval to:

- Assist in your treatment, by talking with the doctors involved in your plan of care to decide what's best for you.

- Determine whether we will pay for the services provided to you, such as deciding if a health care service is *medically necessary*.

- Conduct our health care operations, which in-include things like quality improvement programs.

When may Neighborhood share my health information with others?

We may also use or disclose your information in the following situations without your consent:

- To public health authorities for the purpose of controlling disease.

- To authorities allowed by law to receive reports of child abuse or neglect. In addition, we may disclose to these authorities if we believe you have been a victim of abuse, neglect or domestic violence.

- To appropriate organizations to assist in disaster relief efforts.
- To health oversight agencies that license health care professionals, and that conduct investigations and inspections of health care professionals.
- To a person who may have been exposed by you to a communicable disease
- To report adverse reactions to medications, product defects, and other information, if required by the Food and Drug Administration.
- In the course of any legal action, in response to a court order or, sometimes in response to a subpoena, as long as you have been duly notified or attempts to notify you have been made according to law and the subpoena has not been withdrawn.
- To law enforcement authorities, as long as all applicable legal requirements are met.
- To a medical examiner, such as for identification purposes or determining the cause of death.
- To prevent or lessen a serious and imminent threat to the health or safety of a person or the public if we believe that the disclosure is necessary.
- To comply with workers' compensation laws and other similar programs.
- To you and the Secretary of the United States Department of Health and Human Services ("Secretary") to investigate or determine our compliance with the federal privacy regulations.
- In an *emergency*, we may also share your health information without your approval when we are required by law or public health authorities to do so.

Does Neighborhood need my approval before it shares my health information with others?

Except for the purposes listed above and those permitted or required by the government, Neighborhood will not share your information without your written approval. Even when you have given your approval, you can change your mind as long as you do so in writing before we have shared your information.

What are my health information rights?

You have the right to:

- Get a paper copy of this notice if you ask for it.

- Ask us to limit the way we share your information, although we are not required to agree to what you ask.
- Look at and get a copy of the health information we have about you, as provided by law.
- Ask us to change information we have about you in our member file. You must ask us in writing and tell us why you are asking for the change, although we are not required to agree to the change.
- Ask us to contact you in an alternative way. For example, you may ask us to contact you at work only.
- Take back your approval that we share your information. However, you can only do that if the information hasn't already been shared.
- Receive an accounting of when we shared your information, except if it was for payment, treatment or operations, or with your approval.

What are Neighborhood's duties?

Neighborhood uses many methods to protect your oral, written and electronic health information from illegal use or disclosure. We are required by law to:

- Keep your health information private.
- Provide you with this notice and follow the rules listed here.
- Let you know if we cannot agree to limit how we share your information.
- Agree to reasonable requests to contact you by alternative means or at alternative locations.
- Get your written approval to share your health information for reasons other than those listed above and permitted by law.

Not only do all the *provider*s in our network know that your information is private and confidential, but Neighborhood's employees know that too. We use training programs for our employees and policies and procedures supported by management oversight to ensure that our employees know the procedures they need to follow to make sure that your information - whether in oral, written or electronic format - is secure and safeguarded. Additionally, we have other vendors sign Business Associate Agreements that clearly outline their requirement to protect your information and our expectations concerning protecting your oral, written or electronic health information.

Neighborhood reserves the right to change its privacy practices. If our practices change, we will revise this notice and send it to all Neighborhood Members. The new practices would apply to all of the health information we have, including the health information we already have about you.

What if I have questions or need help with this?

If you need help understanding this notice or you want to exercise any of your rights stated within this notice, please contact Neighborhood *Member Services* at 1-800-459-6019.

What if I think Neighborhood shared my information incorrectly?

You may complain to the Neighborhood Privacy Officer by calling 1-800-963-1001 and asking for the Director of Organizational Development and Human Resources, or by writing to:

> Chief Privacy Officer, Attn: Director of Organizational Development and Human Resources, Neighborhood Health Plan of Rhode Island
> 299 Promenade Street
> Providence, Rhode Island 02908.

You also have the right to complain, in writing, to the Secretary of the United States Department of Health and Human Services. Please ask us if you need help doing that. Your benefits will not be affected if you make a complaint. Here is the address and phone number:

> Office for Civil Rights
> U.S. Department of Health and Human Services
> JFK Federal Building, Room 1875, Boston, MA 02203
> 1-866-627-7748

You can also contact Neighborhood's Compliance Hotline (1-800-826-6762) to report suspected incidents.

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

Section 1.6 You have the right to respectful, personal attention without regard to your race, national origin, gender, age, sexual orientation, religious affiliation, or preexisting conditions

What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about **discrimination**, call the Office for Civil Rights

If you believe you have been **treated unfairly or your rights have not been respected** due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it **about something else**?

If you believe you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

- You can **call *Member Services*** (phone numbers are printed on the back cover of this booklet).

Section 1.7 You have the right to obtain a second medical opinion for medical and surgical concerns

As a Neighborhood member, you have the right to receive a second opinion. This means you can see someone else if you do not think you should have the treatment or surgery your doctor recommends. You may want another doctor's opinion.

If the doctor you would like to see is not in our network, you will need approval from Neighborhood first. This is called *preauthorization*. *Preauthorization* is not required when you seek a second or third opinion from a doctor in our network. Call Neighborhood *Member Services* at 855-321-XCHG (855-321-9244) to find a doctor for a second or third opinion.

Section 1.8 You have the right to a candid discussion of appropriate or *medically necessary* treatment options for your conditions, regardless of cost or benefit coverage

You have the right to get full information from your doctors and other health care *provider*s when you go for medical care. Your *provider*s must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any *experimental* treatments.

- **The right to say "no.**" You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.

- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a *provider* has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 7 of this booklet tells how to ask the plan for a coverage decision.

Section 1.9 You have the right to voice complaints or appeals about Neighborhood or the care provided by its providers

If you have any problems or concerns about your *covered services* or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 7, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an *appeal* to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an *appeal*, or make a complaint – **we are required to treat you fairly.**

Section 1.10 You have the right to make recommendations about Neighborhood's Member Rights and Responsibilities policies

You can make recommendations about Neighborhood's Member Right and Responsibilities policies by calling *Member Services*.

SECTION 2 You have some responsibilities as a member of the plan

Section 2.1 Your responsibilities

Things you need to do as a member of the plan are listed below. If you have any questions, please call *Member Services* (phone numbers are printed on the back cover of this booklet). We're here to help.

When you enroll with NHPRI Exchange Health Plan, you agree to:

- Choose a *Primary Care Provider* (*PCP*) and Primary Care Site. Your *PCP* will coordinate all of your medical care. You may change your *PCP* at any time by calling Neighborhood *Member Services* 1-800-459-6019.
- Have all of your medical care provided by or arranged by a Neighborhood participating doctor.
- Carry your Neighborhood Identification Card with you and show it whenever you seek medical care.
- Provide, to the extent possible, information that Neighborhood and its practitioners and *provider*s need to care for you.
- Learn about your health problems and help plan treatment you and your *PCP* agree on.
- Follow the plans and instructions for care that you have agreed on with your *provider*s.
- Talk with your *PCP* about all specialty care. If you need a specialist, your *PCP* will work with you to make sure you get quality care.
- Call your *PCP* first for help if you have an urgent medical condition. If an *emergency* is life threatening, go immediately to the nearest Emergency Room or call 911. You (or a friend or relative) should contact your *PCP* the next day.
- Let Neighborhood know about changes to your name, home address, telephone number, marital status, number of *dependent*s or if you have other insurance coverage.
- Pay network providers the deductible, copayment, and the difference between the maximum benefit and our allowance (if any) that may apply to covered health care services

- Pay your premiums.
- Pay the cost of all excluded services and items.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

Neighborhood wants you to have quality health care services. These services should meet your needs. They should happen in a timely and respectful manner. We are committed to solving any concerns you may have about how the plan is operated, your benefits, or the quality of healthcare you receive from *network provider*s. To serve you better, Neighborhood has the following processes (each one described in detail below) depending on the type of concern you have.

- *Member* inquiry process
- *Member complaint* process
- Internal *appeal*s process (including fast *appeal*s)
- External review

Which process do you use? That depends on the type of problem you are having. The following descriptions will help you identify the right process to use.

SECTION 2 Member inquiry

Section 2.1 A member inquiry

An inquiry is any communication you make to the plan asking us to address a plan action, policy or procedure. This is an informal process used to resolve most Inquiries.

The inquiry process is not used to resolve concerns about the quality of care received by you from a *network provider* or an adverse determination (coverage denial based on medical necessity) – If your concern involves:

- The quality of care you received from a *network provider* - *Member Services* will refer your concern directly to our complaint process (see below).
- Denial of coverage - *Member Services* will refer your concern directly to our *appeal*s Process (see below).

Section 2.2 Making an Inquiry

Member inquiry process

Call *Member Services* at 1-800-459-6019 to discuss your concern. We will make every effort to resolve your concerns, and in most cases will respond by phone to you within 3 working days. If you tell us that you are not satisfied with decisions, or we were unable to resolve your issue, .you may choose to file a *complaint* or *appeal*. The process we use depends on the type of Inquiry that you made. If you do this, you will receive written acknowledgement and written resolution in accordance with the timelines outlined below.

SECTION 3 Complaint process

Section 3.1 A complaint

Member complaint

A *complaint* is a formal complaint about actions taken by Neighborhood or a Neighborhood Plan *provider*. The member complaint process does not apply to requests for a review of a denial of coverage. If you are seeking such a review, please see the "*Member appeals*" section below.

We have two types of *complaints*: administrative *complaints* and quality of care *complaints*. We describe the two types of *complaints* below.

Administrative *complaint*

An administrative *complaint* is a complaint about a Neighborhood employee, department, policy, or procedure, or about a billing issue. Examples of administrative complaints include the following:

- Respecting your privacy
    - Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
- Disrespect, poor customer service, or other negative behaviors
    - Has someone been rude or disrespectful to you?
    - Are you unhappy with how our *Member Services* has treated you?

- Do you feel you are being encouraged to leave the plan?

- Waiting times
  - Are you having trouble getting an appointment, or waiting too long to get it?
  - Have you been kept waiting too long by doctors or other health professionals? Or by our *Member Services* or other staff at the plan?
  - Have you been kept waiting too long on the phone, in the waiting room, or in the exam room?

- Cleanliness
  - Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

- Information you get from us
  - Do you believe we have not given you a notice that we are required to give?
  - Do you think written information we have given you is hard to understand?

Quality of Care Complaints

A quality of care *complaint* is a complaint about the quality of care or services that you have received. You may have concerns about your medical care. If so, you should discuss them directly with your *provider*. You may not be satisfied with your *provider*'s response or may not want to address your concerns directly with your *provider*. If so, you may contact *Member Services* to file a quality of care *complaint*.

Section 3.2 How and where to file a complaint

It is important that you contact us as soon as possible to explain your concern. *Complaint*s may be filed either verbally or in writing.

If you choose to file a *complaint* verbally, please call Neighborhood's *Member Services* at 1-800-459-6019. A *Member Services* Specialist will document your concern and forward it to an Grievance and Appeals Analyst in the Grievance and Appeals Unit.

To accurately reflect your concerns, you may want to put your *complaint* in writing.

Send written *complaint*s to:

Member Services Grievance and Appeals
Neighborhood Health Plan of Rhode Island
299 Promenade Street
Providence, RI 02908

Your explanation should include:

- Your name and address,
- Your Member ID number,
- Daytime home phone number ,
- A detailed description of your concern. This includes relevant dates, any applicable medical information, and *provider* names, and
- Any supporting documentation.

Release of Medical Records: We may request a signed Authorization to Release Medical Records form. This form authorizes *provider*s to release medical information to us. It must be signed and dated by you or your Authorized Representative. When signed by an Authorized Representative, appropriate proof of authorization to release medical information must be provided.)

If an Authorization to Release Medical Records form is not included with your *complaint*, *Member Services* will promptly send you a blank form. It is very important that you fill out and send us this form. This allows us to obtain medical information we will need to address your *complaint*. If we do not receive this form within 30 calendar days of the date we received your *complaint*, we may respond to your *complaint* without having reviewed relevant medical information. In addition, if we receive the form from you but your *provider* does not give us your medical records in a timely fashion, we will ask you to agree to extend the time limit for us to respond to your *complaint*. If we cannot reach agreement with you on a timeline extension, we may respond to your *complaint* without having reviewed relevant medical information.

Complaint resolution:

- If your *complaint* requires us to review your medical records, the review does not begin until we receive from you a signed "Authorization to Release Medical Information" form. We have a sixty (60) day review period from receipt of your medical information. If your

complaint does not require us to review your medical records, the 30 day calendar day period begins on the next working day following the day the *complaint* was received.

The time limits in this process may be waived or extended beyond the time. This would be done by mutual written agreement between you and Neighborhood.

SECTION 4 Internal appeals process

Section 4.1 An internal appeal

Internal appeal

What is an internal *appeal*? An internal *appeal* is a request for a review of a denial of coverage for a service or supply that has been reviewed and denied by Neighborhood based on:

- Medical necessity (an adverse determination); or
- A denial of coverage for a specifically excluded service or supply.

An *appeal* is a formal request by you for review of a Benefit Denial, an Adverse Determination, or a Retroactive Termination of Coverage – all as specifically defined as follows:

Medical *appeal*

Adverse Determination: A plan decision, based on a review of information provided, to deny, reduce, modify or terminate an admission, continued *inpatient* stay or the availability of any other health care services, for failure to meet the requirements for coverage based on: medical necessity; appropriateness of health care setting and level of care; or effectiveness. These are often known as medical necessity denials because in these cases the plan has determined that the service is not *medically necessary* for you.

Administrative *appeal*

- **Benefit Denial**:
    - A plan decision, made before or after you have obtained services, to deny coverage for a service, supply or drug that is specifically limited or excluded from coverage in this *Certificate of coverage*; or
    - A plan decision to deny coverage for a service, supply or drug because you are no longer eligible for coverage under the plan. (This means you no longer meet the plan's eligibility criteria.)
- **Retroactive Termination of Coverage**: A retroactive cancellation or discontinuance of enrollment as a result of the plan's determination that: you have performed an act,

practice or omission that constitutes fraud; or you have intentionally misrepresented a material fact with regard to the terms of the plan.

Section 4.2 Choosing to use the internal appeals process

Examples of situations when to use the *appeal*s process include the following:

- You are not getting certain medical care you want, and you believe that this care is covered by our plan.
- Our plan will not approve the medical care your doctor or other medical *provider* wants to give you, and you believe that this care is covered by the plan.
- You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.

The Neighborhood Grievance and Appeals Unit will coordinate a review of all of the information submitted upon *appeal*. That review will consider your benefits as detailed in this *Certificate of coverage*. You are entitled to two (2) levels of internal review.

Section 4.3 How and where to file an internal appeal

Internal appeal

It is important that you contact us as soon as possible to explain your concern. You have ninety (90) days from the date you were notified of the denial of benefit coverage, *claim* payment, or first level *appeal* denial to file an *appeal*. *Appeal*s may be filed either verbally or in writing.

To file a verbal *appeal*, call *Member Services*. A *Member Services* Specialist will document your concern and forward it to a Grievance and Appeals Analyst in the Grievance and Appeals Department. For verbal *appeal*s related to Mental Health or Chemical dependency, you must call 1-800-215-0058. If you file an oral *appeal*, we will write a summary of your *appeal* and send you a copy within 48 hours of receipt.

To reflect your concerns accurately, you may want to put your *appeal* in writing. Then, send it to:

Member Services Complaints and Appeals
Neighborhood Health Plan of Rhode Island
299 Promenade Street

Providence, RI 02908

Your explanation should include:

- Your name and address
- Your Member ID number
- A detailed description of your concern. This includes relevant dates, any applicable medical information, and *provider* names, and
- Any supporting documentation.

Plan acknowledgement of your *appeal*. Within five (5) calendar days of receipt of a written or verbal administrative or medical *appeal*, the Grievance and Appeals Unit will mail or call you to phone acknowledge of our receipt of the medical *appeal*.

Section 4.4 Medical records release

Release of Medical Records: We may request a signed Authorization to Release Medical Records form. This form authorizes *provider*s to release medical information to us. It must be signed and dated by you or your Authorized Representative. (When signed by an Authorized Representative, appropriate proof of authorization to release medical information must be provided.)

Section 4.5 How the medical appeal process works

We will review your medical *appeal* and make a decision, within 15 days. We will notify you by sending you a decision letter.

Who reviews *appeal*s?

First level *appeal*s of a medical necessity determination will be reviewed by a licensed *provider*: with the same licensure status as the ordering *provider* or a licensed *provider* or a licensed dentist; and who did not participate in any of the prior decisions on the case.

Second level *appeal*s will be reviewed by a licensed *provider* in the same or similar specialty as typically treats the medical condition, procedure or treatment under review.

A designated reviewer will review *appeal*s involving non-*covered services*. That person will be from the Grievance and Appeals and Department.

Appeal response letters

The letter you receive from Neighborhood will include identification of the specific information considered for your *appeal* and an explanation of the basis for the decision. Notification of the steps requested the next level of internal *appeal* or an external review by an External Appeals Agency, designated by the Rhode Island Department of Health, as appropriate.

Also, a first level adverse *appeal* determination letter will notify you that should you file a second level *appeal*, you have the right to: (1) inspect the *appeal* review file and; (2) add information prior to our reaching a final decision.

Finally, a second level adverse *appeal* determination letter will include: fee information for filing an external review; and a statement that if Neighborhood's decision is overturned by the external appeals agency, you will be reimbursed by NHRPI within sixty (60) days of the date you are notified of the overturn for your share of the *appeal* fee.

Section 4.5 A fast (expedited) appeal

Fast *appeal*

We recognize that there are circumstances that require a quicker turnaround than the fifteen (15) calendar days allotted for the standard *appeal*s process. A fast *appeal* determination is for services that have not yet been rendered (a pre-service review). Services that have already been rendered (retrospective review) are not eligible for fast (urgent) review.

We will expedite an *appeal*:

- When there is an ongoing service about to terminate or a service to be delivered imminently whereby a delay in treatment would seriously jeopardize your life and health or jeopardize your ability to regain maximum function.

- Additionally, we will expedite your *appeal* if a medical professional determines it involves emergent health care services (defined as medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition:

    - Placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy;

- Constituting a serious impairment to bodily functions; or
- Constituting a serious dysfunction of any bodily organ or part.

How and where can I file a fast (expedited) *appeal*?

If you feel your request meets the criteria cited above, you or your attending *provider* should contact *Member Services* at 1-800-963-1001.

Neighborhood will make a decision as expeditiously as your health condition might require, but no later than 72 hours after receipt of the request.

Section 4.6 How the administrative appeals process works

We will respond to your administrative *appeal* in writing within thirty (30) calendar days of our receipt of your administrative *appeal*. The determination letter will provide you with information regarding our determination.

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

SECTION 5 External review

Section 5.1 An external review

Neighborhood provides for an independent external review by an external appeal agency for final adverse determinations. These are decisions based on medical necessity.) The Rhode Island Department of Health has designated an external appeal agency that performs independent reviews of final adverse medical necessity decisions. The external review agency is not connected in any way with Neighborhood. Please note that *appeal*s for coverage of services excluded from coverage under your plan are not eligible for external review. This external *appeal* is voluntary. This means you may choose to participate in this level of *appeal*, or you may file suit in an appropriate court of law (Please see Legal Action, below).

Section 5.2 How and where to request an external review

To initiate this external *appeal*, you must send a letter to us within four months of the receipt of your second level adverse determination letter. In that letter, you must include:

- Any additional information that you would like the external review agency to consider; and
- Your share of the fee for this review will be no greater than $25. (Information regarding current external *appeal* fees will be included in second level adverse *appeal* determination letters.)
- Cost of the appeal will be born by Neighborhood

Within five (5) days of receipt of your written request and your share of the fee, Neighborhood will forward the complete review file, including the criteria utilized in making its decision, along with the balance of the fee to the external appeal agency.

For standard *appeal*s, the external appeal agency will complete its review and make a final determination within ten (10) business days. For *appeal*s determined to be for an emergent health care service, the external appeal agency will complete a review and make a final determination within two (2) business days of receipt.

The external appeal agency will provide notice to you and your *provider* of record of the outcome of the external *appeal*. The external review will be based on the following:

- The review criteria used by Neighborhood to make the internal *appeal* determination;
- The medical necessity for the care, treatment or service for which coverage was denied; and
- The appropriateness of the service delivery for which coverage was denied.

The decision of the external appeals agency is binding. However, any person who is not satisfied by a final decision of the external appeals agency is entitled to judicial review in a court of competent jurisdiction.

If the external appeals agency overturns Neighborhood's second level *appeal* decision, Neighborhood will reimburse you for your share of the *appeal* fee within 60 days of the notice of the decision. In addition, we will send you a written notice within five (5) business days of receipt of the written decision from the *appeal* agency. This notice will:

- Include an acknowledgement of the decision of the agency;
- Advise of any procedures that you need to take in order to obtain the requested coverage or services;
- Advise you of the date by which the payment will be made or the authorization for services will be issued by Neighborhood; and
- Include the name and phone number of the person at Neighborhood who will assist you with final resolution of *appeal*.

SECTION 6 Legal action

Section 6.1 Legal action

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

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

Under state law, you may not begin court proceedings prior to the expiration of sixty (60) days after the date you filed your *claim*. In no event may legal action be taken against us later than three (3) years from the date you were required to file the *claim*.

SECTION 7 Our right to withhold payments

Section 7.1 Our right to withhold payments

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

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

Chapter 8. Ending your Membership in the plan

SECTION 1 Introduction

Section 1.1 Ending your membership in our plan

Ending your Membership in Neighborhood Exchange Health Plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you want to leave.
- There are also limited situations where you do not choose to leave, but we may end your Membership. Section 3 tells you about situations when we may end your Membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your Membership ends.

SECTION 2 When you can end your membership in our plan

Section 2.1 If you decide to discontinue coverage

If you decide to discontinue coverage, we must receive your notice within 14 days to Neighborhood or the Exchange to end this agreement prior to the requested date of cancellation. If we do not receive your notice prior to the requested date of cancellation, you may be responsible for paying another month's *member* premium. This agreement will end for a covered *dependent* if the *dependent* no longer qualifies as an eligible *dependent*.

An enrolled *dependent*'s coverage ends when the *subscriber*'s coverage ends, or when the *dependent* no longer meets the definition of *dependent*, whichever occurs first. See Chapter 1, Section 2.3, "Continuing eligibility for *dependents*" for more information.

If you have any questions or would like more information on when you can end your Membership: you can call *Member Services* (phone numbers are printed on the back cover of this booklet

SECTION 3 When Neighborhood may end your membership in the plan

Section 3.1 When we may end your membership in the plan

Neighborhood may end your Membership in the plan if any of the following happen:

- Failure to pay premiums or contributions in accordance with the terms of the health insurance coverage

- Failure to make timely premium payments;

    - A grace period of ten (10) days will be granted for the payment of each Premium after the first Premium. During that grace period, this Contract will continue in force, subject to our right to cancel in accordance with the cancellation privileges of this Contract.

    - If any renewal Premium is not paid within the grace period, coverage may be reinstated in accordance with Rhode Island Statute 27-18-3(4).

    - If you are a member who receives advance payments of premium tax credit, you will have a 3-month grace period and we must provide you with advance notice that your payments are late, unless the *Exchange* has accepted the obligation to do so instead of Neighborhood.

    - For all other Members, we will give you notice of late payment and a 31-day grace period before your insurance by us will end.

- Performance of an act or practice that constitutes fraud or there is an intentional misrepresentation of material fact under the terms of the coverage;

- You no longer reside, live, or work in the service area. This applies to all Members equally and will not consider any health status-related factor;

- If coverage that is made available through an association and your Membership in the association (on the basis of which the coverage is provided) stops. This applies to all Members equally and will not consider any health status-related factor.

- Neighborhood ceases to offer coverage in accordance with subsections (c) and (d) of this section;

- If Neighborhood stops offering your particular type of health insurance coverage. In this case we will:

    - At least ninety (90) days prior to the date of discontinuation we provide notice of the discontinuation to each covered individual provided coverage;

    - Offer you the opportunity to purchase any other individual health insurance coverage currently being offered by Neighborhood; and

- Treat all Members equally and will not consider any health status-related factor.

- You are no longer eligible for coverage through the *Exchange*
- You become eligible for either or both parts of Medicare or under any other state or federal law providing for benefits similar to those provided by this Plan

*Note: Children are not required to maintain primary residence in the Service Area. However, care outside of the service area is limited to *emergency* or urgent care only.

Where can you get more information?

If you have questions or would like more information on when we can end your Membership:

- You can call ***Member Services*** for more information (phone numbers are printed on the back cover of this booklet).

Section 3.2 When a member is no longer eligible

Loss of Eligibility

Your coverage ends on the date you no longer meet the eligibility rules described in Chapter 3, Section 2

Note: Your coverage will terminate retroactively. This is done back to the date you are no longer eligible for coverage

Section 3.3 If you move out of the service area

What should you do if this happens?

If you are a *subscriber* or *spouse* and you move out of the Service Area, coverage ends on the date you move. Children are not required to maintain primary residence in the Service Area. However, care outside of the service area is limited to *emergency* or urgent care only.

Before you move, call *Member Services* to notify us of your move date. You may have kept a residence in the Service Area, but been out of the Service Area for more than 90 days. If this happens, coverage ends 90 days after the date you left the Service Area.

For more information about coverage available to you when you move out of the Service Area, contact *Member Services*.

Section 3.4 Membership termination for acts of physical or verbal abuse

We may terminate your coverage if you commit acts of physical or verbal abuse which: are unrelated to your physical or mental condition; pose a threat to any *provider*, any Neighborhood Health Plan Member, or Neighborhood Health Plan or any Neighborhood Health Plan employee.

Section 3.5 Membership termination for misrepresentation or fraud

We may terminate your coverage for misrepresentation or fraud during the first two years of coverage under this plan. If your coverage is terminated for misrepresentation or fraud, we may not allow you to re-enroll for coverage with us under any other plan (such as an employer's plan) or type of coverage (for example, coverage as a *dependent* or spouse).

What are acts of misrepresentation or fraud?

Examples of misrepresentation or fraud include:

- False or misleading information on your application;
- Enrolling as a *spouse* someone who is not your *spouse*;
- Receiving benefits for which you are not eligible;
- Keeping for yourself payments made by Neighborhood that were intended to be used to pay *provider*; or
- Allowing someone else to use your Member ID card.

Date of termination

If we terminate your coverage for misrepresentation or fraud, your coverage will end as of a later date chosen by us. During the first two years of coverage, we reserve the right to revoke coverage and deny payment of *claim*s retroactive to your *effective date* for any false or misleading information on your application. Should we decide to end your enrollment, we will provide at least thirty (30) days advance written notice.

You can also look in Chapter 7, Section 3 for information about how to make a complaint. We will pay for all *covered services* you received between: your *effective date*; and your termination date, as chosen by us. We may retroactively terminate your coverage back to a date no earlier than your *effective date*. We may use any Premium you paid for a period after your termination date to pay for any *covered services* you received after your termination date.

The Premium may not be enough to pay for that care. In this case, Neighborhood, at its option, may: pay the *provider* for those services and ask you to pay us back; or not pay for those services. In this case, you will have to pay the *provider* for the services.

SECTION 4 HIPAA certificate of creditable coverage

Section 4.1 Certificate of creditable coverage

HIPAA certificate of creditable coverage

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

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

SECTION 5 Continuation of coverage

Section 5.1 Continuation of coverage

Coverage is guaranteed renewable, and Neighborhood may non-renew or cancel coverage under the Plan only for nonpayment of premiums, fraud, market exit, movement outside of service area, or if the member is no longer eligible.

Chapter 9. Other plan provisions

SECTION 1 General legal provisions

Section 1.1 Subrogation

Neighborhood's right of subrogation

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

You may have a legal right to recover some or all of the costs of your health care from someone else (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. This includes such costs to any *dependent* covered under this plan.

Neighborhood may cover health care costs for which a Third Party is responsible. In this case, we may require that Third Party to repay us the full cost of all such benefit provided by this plan. Our rights of recovery apply to any recoveries made by you or on your behalf from any source.

This includes, but is not limited to:

- Payments made by a Third Party;
- Payments made by any insurance company on behalf of the Third Party;
- Any payments or rewards under an uninsured or underinsured motorist coverage policy;
- Any disability award or settlement;
- Medical payments coverage under any automobile policy;
- Premises or homeowners' medical payments coverage;
- Premises or homeowners' insurance coverage; and
- Any other payments from a source intended to compensate you for Third Party injuries.

We have the right to recover those costs in your name. We can do this with or without your consent, directly from that person or company. 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.

Personal injury protection/med pay benefits

You may be entitled to benefits under your own or another individual's automobile coverage, regardless of fault. These benefits are commonly referred to as Personal Injury Protection (PIP) and Medical Payments (MedPay) benefits. To the extent permitted under applicable state law, our coverage is secondary to both PIP and MedPay benefits. If we pay benefits before PIP or MedPay benefits have been exhausted, we may recover the cost of these benefits as described above.

Neighborhood's right of reimbursement

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

This provision applies in addition to the rights described above. You may recover money by suit, settlement, or otherwise. If this happens, you are required to reimburse us for the cost of health care services, supplies, medications, and expenses for which we paid or will pay. This right of reimbursement starts when (1) we have provided health care benefits for expenses where a Third Party is responsible and (2) you have recovered any amounts from any sources. This includes, but is not limited to:

- Payments made by a Third Party;
- Payments made by any insurance company on behalf of the Third Party;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any disability award or settlement;
- Medical payments coverage under any automobile policy;
- Premises or homeowners' medical payments coverage;
- Premises or homeowners' insurance coverage; and
- Any other payments from a source intended to compensate you, where a Third Party is responsible.

We have the right to be reimbursed up to the amount of any payment received by you. This is regardless of whether: (a) all or part of the payment to you was designated, allocated, or characterized as payment for medical expenses; or (b) the payment is for an amount less than that necessary to compensate you fully for the illness or injury.

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 health care services and supplies, and expenses, that we paid or will pay for your illness or injury;
- 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 benefits associated with Third Party responsibility;
- To do nothing to prejudice our rights as described 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 all benefits provided by this plan;
- To serve as a constructive trustee for the benefit of the plan over any settlement or recovery funds received as a result of Third Party responsibility;
- That we may recover the full cost of all benefits 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 without our prior express written consent; and

- That in the event you or your representative fails to cooperate with Neighborhood, you will be responsible for all benefits provided by this plan in addition to costs and attorney's fees incurred by Neighborhood in obtaining repayment.

Workers' compensation

Employers provide workers' compensation insurance for their employees. Employers do this to protect them in case of work-related illness or injury.

If you have a work-related illness or injury, you and your employer must ensure that all medical *claim*s related to the illness or injury are billed to your employer's workers' compensation insurer. We will not provide coverage for any injury or illness for which it determines that the *member* is entitled to benefits pursuant to: (1) any workers' compensation statute or equivalent employer liability; or (2) indemnification law. This is the case whether or not the employer has obtained workers' compensation coverage as required by law.

We may pay for costs of health care services or medications for any work-related illness or injury. If we do this, we have the right to recover those costs from you, the person, or company legally obligated to pay for such services, or from the *provider*. If your *provider* bills services or medications to us for any work-related illness or injury, contact the <Liability and Recovery Department Name >at <TELEPHONE NUMBER>

Subrogation Agent

We may contract with a third party to administer subrogation recoveries. In such case, that subcontractor will act as our agent.

Constructive trust

By accepting benefits from Neighborhood, you agree that if you receive any payment from any responsible party as a result of an injury, illness, or condition, you will serve as a constructive trustee over the funds that constitute such payment. This is the case whether the payment of such benefits is made to you directly, or made on your behalf (for example, to a *provider*).Failure to hold the funds in trust will be deemed a breach of your fiduciary duty to Neighborhood.

Section 1.2 Amendments to this policy

We reserve the right, without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy. Any provision of the Policy which is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the

Policy is delivered) is amended to conform to the minimum requirements of such statutes and regulations. No other change may be made to the Policy unless it is made by an Amendment or Rider signed by one of our officers. All of the following conditions apply:

- Amendments to the Policy are effective 31 days after we send written notice.
- Riders are effective on the date we specify.
- No agent has the authority to change the Policy or to waive any of its provisions.

No one has authority to make any oral changes or amendments to the Policy

Section 1.3 Genetic information

We do 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 individual or family Members of an individual before, in connection with enrollment, or at any time for underwriting purposes.

Section 1.4 Our rights to make payments and recover overpayments

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

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

Section 1.5 Limitation of action

You cannot bring any legal action against us to recover reimbursement prior to the expiration of sixty days after a request for benefits has been filed and no such action can be brought at all unless brought within three years from the expiration of time to submit a request for benefits.

Section 1.6 Circumstances beyond Neighborhood's control

Neighborhood will not be responsible for a failure or delay in arranging for the provision of services in cases of circumstances beyond the reasonable control of Neighborhood. Such circumstances include, but are not limited to: major disaster; epidemic; strike; war; riot; and civil insurrection. In such circumstances, we will make a good faith effort to arrange for the provision of services. In doing so, we will take into account the impact of the event and the availability of *network provider*s.

Section 1.7 Patient protection disclosure

You do not need prior authorization from Neighborhood or from any other person (including a *Primary Care Provider*) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining *preauthorization* for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specializes in obstetrics or gynecology, contact *Member Services* or see our Web site at www.Neighborhood.org.

SECTION 2 Your relationship with us

We do not provide medical services or make treatment decisions. This means:

- We do not decide what care you need or will receive. You and your Physician make those decisions.
- We communicate to you decisions about whether the Enrolling Group's Benefit plan will cover or pay for the health care that you may receive.
- The plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

SECTION 3 Our relationship with network providers

The relationships between us and network *provider*s are solely contractual relationships between independent contractors. Network *provider*s and are not our agents or employees. We and our employees are not agents or employees of *network provider*s. We do not provide health care services or supplies. We do not practice medicine. We arrange for health care *provider*s to be part of a Network and we pay Benefits. Network *provider*s are independent *provider*s who run their own offices and facilities. Our credentialing process confirms public information about the *provider*s' licenses and other credentials. It does not assure the quality of the services provided. They are not our employees and we do not have any other relationship with Network *provider*s. We are not liable for any act or omission of any *provider*.

SECTION 4 Your relationship with network providers

The relationship between you and any *provider* is that of *provider* and patient.

- You are responsible for choosing your own *provider*.
- You are responsible for paying, directly to your *provider*, any copayments, coinsurance, any annual *deductible* and any amount that exceeds eligible expenses.
- You are responsible for paying, directly to your *provider*, the cost of any non-Covered Service.
- You must decide if any *provider* treating you is right for you. This includes Network *provider*s you choose and *provider*s to whom you have been referred.
- You must decide with your *provider* what care you should receive.
- Your *provider* is solely responsible for the quality of the services provided to you.

SECTION 5 How we coordinate your Benefits when you are covered by more than one Plan

Section 5.1 Introduction to Coordination of Benefits (COB)

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

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

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

Section 5.2 Definitions

The following definitions apply to Section 5:

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

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

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

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

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

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

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

Secondary plan means a *plan* which is not a *primary plan*.

Section 5.3 When you have more than one agreement with NHPRI

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

Section 5.4 How we Coordinate your benefits when you are covered by more than one plan

When You Are Covered By More Than One Insurer

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

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

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

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

Non-Dependent/Dependent - If you are covered under a plan and you are the main subscriber, the benefits of that plan will be determined before the benefits of a plan which covers you as a dependent. If, however, you are a Medicare beneficiary, then, in some instances, Medicare will be Secondary and the plan which covers you as the main subscriber or as a dependent will provide the benefits first.

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

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

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

- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse of the parent with custody of the child; AND
- Finally, the plan of the parent not having custody of the child.

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

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

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

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

In general, if you use more benefits than you are covered for during a benefit period, the following formula is used to determine coverage:

The insurer covering you first will cover you up to its allowance. Then, the other insurer will cover any allowable benefits you use over that amount. It will never be more than the total amount of coverage that would have been provided if benefits were not coordinated.

Maximum benefits paid by first insurer + Any remaining allowable expense paid by other insurer = **Total Benefits Paid.**

Chapter 10. Definitions of important words

Adoptive child – A *child* is an *adoptive child* as of the date he or she:

- Is legally adopted by the *subscriber*; or
- Is placed for adoption with the *subscriber*. This means that the *subscriber* has assumed a legal obligation for the total or partial support of a *child* in anticipation of adoption. If the legal obligation ceases, the *child* is no longer considered placed for adoption.

We consider a foster child an *Adoptive Child* as of the date of placement for adoption.

Appeal – An *appeal* is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already received. You may also make an *appeal* if you disagree with our decision to stop services that you are receiving. For example, you may ask for an *appeal* if we do not pay for an item or service you think you should be able to receive. Chapter 7 explains *appeal*s, including the process involved in making an *appeal*.

Balance billing – A situation in which a *provider* (such as a doctor or hospital) bills a patient more than the plan's cost-sharing amount for services. You only have to pay the plan's cost-sharing amounts when you get services covered by our plan. We do not allow *provider*s to "balance bill" you. See Chapter 4, Section 1.4 for more information about *balance billing*.

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

Certificate of Coverage (COC) --This document, and any future amendments, which describes the health benefits under this contract.

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

Chemical dependency – The chronic abuse of alcohol or other drugs characterized by:

- Impaired functioning;
- Debilitating physical condition;
- The inability to keep from or reduce consuming the substance; or

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

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

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

Child --The following individuals until their 26th birthday:

- The *subscriber*'s or *spouse*'s natural child, stepchild, or *Adoptive Child* who qualifies as a *dependent* for federal tax purposes; or

- Any other *child* for whom the *subscriber* has legal guardianship.

Claim – A request that benefits of a plan be provided or paid.

COBRA – The Consolidated Omnibus Budget Reconciliation Act passed by Congress in 1986. This law provides continuation of individual health plan coverage that would otherwise have ended. COBRA gives certain former employees, retirees, spouses, and *dependent*s the right to temporary continuation of health coverage at individual rates.

Coinsurance – An amount you may be required to pay as your share of the cost for services. *Coinsurance* is usually a percentage (for example, 20%).

Contract year – A twelve (12) month period.

Copayment – An amount you may be required to pay as your share of the cost for a covered service or supply, like a doctor's visit, hospital *outpatient* visit, or a prescription. A *copayment* is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription.

Cost Sharing – The cost you pay for *covered services*. This amount may consist of *deductible*s, copayments, and/or coinsurance.

Covered service – The services and supplies for which we will pay. They must be:

- Described in Chapter 4 of this Certificate (They are subject to the "Benefits not covered by the plan" section in Chapter 4.); and

- *Medically necessary*.

These services include *medically necessary* coverage of pediatric specialty care (this includes mental health care) by *provider*s with recognized expertise in specialty pediatrics.

Covered services do not include any tax, surcharge, assessment, or other similar fee imposed under any state or federal law or regulation on any *provider*, *member*, service, supply, or medication.

Custodial care –

- Care provided primarily to assist in the activities of daily living. Examples include bathing, dressing, eating, and maintaining personal hygiene and safety;
- Care provided primarily for maintaining the *member*'s or anyone else's safety, when no other aspects of treatment require an acute hospital level of care;
- Services that could be provided by people without professional skills or training; or
- Routine maintenance of colostomies, ileostomies, and urinary catheters; or
- Adult and pediatric day care.

In cases of mental health care or substance abuse care, *inpatient* care or intermediate care provided primarily:

- For maintaining the *member*'s or anyone else's safety; or
- For the maintenance and monitoring of an established treatment program,
- When no other aspects of treatment require an acute hospital level of care or intermediate care.

Note: *Custodial care* is not covered.

Deductible – The amount that you must pay each *contract year* before our plan begins to pay for certain covered health care services. For example, if your *deductible* is $1000, we won' pay anything until you have met your $1000 *deductible* for covered health care services subject to the *deductible*. The *deductible* may not apply to all services.

Dependent --The *subscriber*'s spouse, *child*, or *disabled dependent.*

Developmental Services – Therapies, typically provided by a qualified professional using a treatment plan intended to lessen deficiencies in normal age appropriate function. The

therapies are generally meant to limit deficiencies related to injury or disease that have been present since birth. This is true even if the deficiency was detected during a later developmental stage. The deficiency may be the result of injury or disease during the developmental period. *Developmental services* are applied for sustained periods of time to promote acceleration in developmentally related functional capacity. This agreement does not cover *developmental services* unless specifically listed as covered.

Disabled dependent - The *subscriber*'s or spouse's natural *child*, step*child*, or *adoptive child* of any age that:

- Is permanently physically or mentally disabled, or has a disability which can be expected to result in death, or can be expected to last for a period of not less than 12 months; and
- Is financially dependent on the *subscriber*.

Durable Medical Equipment -- Devices or instruments of a durable nature that:

- Are reasonable and necessary to sustain a minimum threshold of independent daily living;
- Are made primarily to serve a medical purpose;
- Are not useful in the absence of illness or injury;
- Can withstand repeated use; and
- Can be used in the home.

Effective Date -- The date, according to our records, when you become a *member* and are first eligible for *covered services*.

Emergency -- An illness or medical condition, whether physical, behavioral, related to substance abuse, or mental, that manifests itself by symptoms of sufficient severity (this includes severe pain.) that the absence of prompt medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in:

- Serious jeopardy to the physical and / or mental health of a *member* or another person (or with respect to a pregnant *member*, the *member*'s or her unborn *child*'s physical and/or mental health); or
- Serious impairment to bodily functions; or

- Serious dysfunction of any bodily organ or part; or

- With respect to a pregnant woman who is having contractions, inadequate time to effect a safe transfer to another hospital before delivery, or a threat to the safety of the *member* or her unborn *child* in the event of transfer to another hospital before delivery.

Some examples of illnesses or medical conditions requiring *emergency* care are severe pain, a broken leg, loss of consciousness, vomiting blood, chest pain, difficulty breathing, or any medical condition that is quickly getting much worse

Eligible person – Is explained in Section 2.1. See Section 2.1 for a detailed description of who is eligible to enroll as a *dependent* under this agreement.

Exchange – The Rhode Island Health Benefits *Exchange* as originally established by Executive Order Number 11-09 to enable people to easily compare health insurance options, learn if they qualify for tax credits, and sign up for health insurance.

Experimental or investigative -- A service, supply, treatment, procedure, device, or medication (collectively "treatment") is considered *experimental* or *investigative* if any of the following apply:

- The drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished or to be furnished; or

- The treatment, or the "informed consent" form used with the treatment, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or federal law requires such review or approval; or

- Reliable evidence shows that the treatment is under study to determine its safety, efficacy, toxicity, maximum tolerated dose, or its efficacy as compared with a standard means of treatment or diagnosis; or

- Evaluation by an independent health technology assessment organization has determined that the treatment is not proven safe and/or effective in improving health outcomes or that appropriate patient selection has not been determined; or

- The peer-reviewed published literature regarding the treatment is predominantly non-randomized, historically controlled, case controlled or cohort studies; or there are few or no well-designed randomized, controlled trials.

Family coverage --Coverage for a *subscriber* and his or her *dependent*s.

Free-Standing ambulatory surgi-center – A state licensed facility which is equipped to surgically treat patients on an *outpatient* basis.

Complaint - A type of complaint you make about us or one of our *network provider*s, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Habilitative services – Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a *child* who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of *inpatient* and/or *outpatient* settings.

Home Health Aide – A *home health aide* provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). *Home health aides* do not have a nursing license or provide therapy.

Inpatient – A patient admitted to a hospital or other health care facility. The patient must be admitted at least overnight.

Maximum benefit – The total benefit allowed under this plan for covered health care services for a particular condition or service.

Out-of-pocket maximum – The most that you pay *out-of-pocket* during the calendar year for *covered services*. Unless otherwise indicated, we will pay up to 100% of our allowance for the rest of the *contract year* once you have met the maximum *out-of-pocket* expense,

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

Medically Necessary - means services or supplies which, under the provisions of this Agreement, are determined to be:

1. appropriate and necessary for the symptoms, diagnosis, treatment or maintenance of a Member's health;
2. provided for preventative care, or for diagnosis or direct care and treatment of a Member's medical condition or mental health status;
3. within standards of good professional practice within the applicable organized professional community;
4. not primarily for the convenience of the Member, the Member's physician or another health care provider; and
5. the most appropriate supply or level of service that can be provided safely.

For inpatient hospital services, this means that acute care as an inpatient is necessary due to the kind of services the Member is receiving or the severity of the Member's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensive medical setting.

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

Member (member of our plan, or "plan member") – A person who is eligible to get *covered services*, who has enrolled in our plan.

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, *complaint*s, and *appeal*s.

Network *provider* (Network) – A *provider* that has entered into an agreement with us.

Non-network *provider* (non-network) – A *provider* that has not entered into an agreement with us or another Neighborhood plan of another state.

Out-of-network *provider* or out-of-network facility – A *provider* or facility with which we have not arranged to coordinate or provide *covered services* to *member*s of our plan.

Out-of-pocket costs – See the definition for "cost sharing" above. A member's cost-sharing requirement to pay for a portion of services received is also referred to as the member's "*out-of-pocket*" cost requirement.

Outpatient – A patient receiving ambulatory care at a hospital or other health care facility. The patient is not admitted overnight.

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

Preauthorization is the approval that you must seek before receiving certain covered health care services. Selected prescription drugs bought at a pharmacy require prescription drug *preauthorization*. *Preauthorization* ensures that services are *medically necessary* and performed in the most appropriate setting. *Network providers* are responsible for obtaining *preauthorization* for all applicable covered health care services. You are responsible for obtaining *preauthorization* when the *provider* is *non-network*. If you do not obtain *preauthorization* and the services are determined to be not *medically necessary* or the

setting in which the services were received is determined to be inappropriate, we will not cover these services/ facilities.

- You may ask for *preauthorization* by telephoning us. For covered health care services (other than behavioral health services), call our *Member Services* Department at 1-800-963-1001.

- For behavioral health services (mental health and chemical dependency) call 1-800-215-0058.

- We encourage you to contact us at least two (2) working days before you receive any covered health care service for which *preauthorization* is recommended.

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

Premium – The total monthly cost of individual or family coverage that the *subscriber* pays to Neighborhood

Preventive care services – Covered health care services performed to prevent the occurrence of disease.

Primary Care *Provider* ("PCP") – A *network provider* who provides primary care services (including family practice, general practice, internal medicine, obstetrics and gynecology, and/or pediatrics), manages routine health care needs, and has been identified as the *Primary Care Provider* for one or more members.

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

These individuals include:

- Midwives;

- Certified registered nurse practitioners;

- Psychiatric and mental health nurse clinical specialists practicing in collaboration with or in the employ of a physician licensed in Rhode Island;

- Counselors in mental health; and

- Therapists in marriage and family practice.

Rehabilitation services – These services include physical therapy, speech and language therapy, and occupational therapy.

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

The services must be:

- Consistent with the nature and severity of illness;
- Be considered safe and effective for the patient's condition; and
- Be used to restore function.

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

Semi-private room – A hospital room with two or more patient beds.

***Skilled* Nursing Facility (SNF) Care** – *Skilled* nursing care and *rehabilitation* services provided on a continuous, daily basis, in a *Skilled Nursing Facility*. Examples of *Skilled Nursing Facility* care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Skilled -- A type of care that is *medically necessary*. This care must be provided by, or under the direct supervision of, licensed medical personnel. *Skilled* care is provided to achieve a medically desired and realistically achievable outcome.

Spouse -- The *subscriber*'s legal *spouse*, according to the law of the state in which you reside.

Spouse also includes the spousal equivalent of the *subscriber* who is the registered Domestic Partner, civil union partner, or other similar legally recognized partner of the *subscriber* who resides in a state or municipal jurisdiction that provides such legal recognition/spousal equivalent rights.

Subscriber - The person:

- Who enrolls in NHPRI Exchange Health Plan and signs the membership application form on behalf of himself or herself and any *dependent*s; and

- In whose name the Premium is paid.

Urgent Care Center – A health care center physically separate from a hospital or other institution with which it is affiliated. It may also mean an independently operated and owned health care center. These centers are also referred to as "walk-in centers".

[Note: this is the back cover for the Certificate of Coverage]

Neighborhood Individual Plan *Member Services*

CALL	855-321-XCHG (855-321-9244) Calls to this number are free. *Member Services* Specialists are available Monday through Friday 8:30 a.m. – 5:00 p.m. *Member Services* also has free language interpreter services available for non-English speakers.
TTY	401-459-6690 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.] Calls to this number are free. 8:30 a.m. – 5:00 p.m.
FAX	401-459-6021
WRITE	Neighborhood Health Plan of Rhode Island 299 Promenade Street Providence, Rhode Island 02908
WEBSITE	www.NHPRI.org

Benefit Overview

This table provides basic information about your benefits under this plan. See "Benefit Limits"and Chapter 4 for detailed explanations of *Covered Services*. This includes certain benefitrestrictions and limitations (for example, visit, day, and dollar maximums).

MEDICAL DEDUCTIBLE

The *Deductible* is the amount you and the enrolled *Members* of your family (if applicable) must pay each year for certain *Covered Services* before payments are made under this certificate of coverage.

Individual Medical *Deductible*.....$3,000 per *Contract Year*
Family Medical *Deductible* .....$6,000 per *Contract Year*

This Family Medical *Deductible* applies for all enrolled *Members* of a family. All amounts any enrolled *Members* in a family pay toward their Individual *Deductibles* are applied toward the Family *Deductible*.
The Family Medical *Deductible* is satisfied in a *Contract Year* when:
•one enrolled *Member* in family meets his or her $3,000 Individual *Deductible*; **and**
•one or more additional enrolled *Members* in that family have paid toward their Individual Medical *Deductibles* a collective amount equal to the remaining balance of the family deductible in any combination. Once the Family Medical *Deductible* has been met during a *Contract Year*, all enrolled *Members* in a family will thereafter have satisfied their Individual *Deductibles* for the remainder of that *Contract Year.*

• The following are not subject to the Medical *Deductible*:
•*Emergency* care;
•Office visits for preventive care*; office visits for family planning; office visits to diagnose and treat illness or injury; mental health and substance abuse services; routine ob/gyn exam; routine eye exam; other vision care from an optometrist; *Outpatient* maternity care (pre-natal and post-partum)**; pediatric dental care; spinal manipulation; chiropractic medicine; acupuncture; nutritional counseling; and health education.
*including diagnostic tests associated with preventive health care, as described in Chapter 4.
**This does not include diagnostic tests such as ultrasounds.
•routine cytological exams (Pap Smears);
•early intervention services for a *Dependent Child;*
•preventive immunizations;
•routine mammograms;
•prostate and colorectal exams;
•Any amounts you pay for prescription drugs. [A separate *Deductible* applies to your prescription drug coverage.] For more information, see "Prescription Drug Benefit" in Chapter 4.]
•Any amount you pay for services, supplies, or medications that are not *Covered Services*.
• Once you meet your *Deductible* in a *Contract Year* for *Covered Services*, you pay only the following:
•Office visit *Copayment* for *Covered Services* not subject to the *Deductible*.
•Emergency room *Copayment*;
•Inpatient Services *Copayment*.
•Day Surgery *Copayment*.
•*Coinsurance*.

Benefit Overview, continued

PHARMACY *DEDUCTIBLE*
The Pharmacy *Deductible* is the amount you and the enrolled *Members* of your family (if applicable) must pay each year for certain *Covered Pharmacy Services* before payments are made under this certificate of c*overage*.

Individual Pharmacy *Deductible*..... $250 per *Contract Year*
Family Pharmacy *Deductible* ….....$500 per *Contract Year*]

This Family Pharmacy *Deductible* applies for all enrolled *Members* of a family.
All amounts any enrolled *Members* in a family pay toward their Individual *Deductibles* are applied toward the Family Pharmacy *Deductible*.
The Family *Deductible* is satisfied in a *Contract Year* when:
•one enrolled *Member* in family meets his or her $250 Individual *Deductible*; **and**
•one or more additional enrolled *Members* in that family have paid toward their Individual *Deductibles* a collective amount equal to the remaining balance of the family deductible in any combination.
Once the Family *Deductible* has been met during a *Contract Year*, all enrolled *Members* in a family will thereafter have satisfied their Individual *Deductibles* for the remainder of that *Contract Year*.

COINSURANCE
Except as described in the "Benefit Overview" table below, the *Member* pays 30% after the deductible is satisfied of the *Reasonable Charge* for certain *Covered Services*. The *Member* is also responsible for any charges in excess of the *Reasonable Charge*.

COPAYMENTS
• ***Emergency* Care:**
• Emergency room.....$200 *Copayment* per visit
• In *Provider's* office .....$25 *Copayment* per visit for care received from a Neighborhood provider.
[Note[s]:
• An Emergency Room *Copayment* may apply if you register in an Emergency room but leave that facility without receiving care.]
• A *Day Surgery Copayment* may apply if *Day Surgery* services are received.
• Urgent Care .. $50 *Copayment* varies depending on type of *Provider* (*PCP* or Specialist) and location in which service is rendered (for example, *Emergency Room,* urgent care center, or physician's office).per visit
•Other *Covered Services*:
• Office Visit.....$50 - *Copayment* per visit for office visits.

Note: This *Copayment* applies to covered *Outpatient* care provided by your *PCP*, amental health/substance abuse *Provider*, or an obstetrician/ gynecologist ("Ob/Gyn"),as well as for *Outpatient* - physical, occupational, or speech therapy services, spinal manipulation, chiropractic medicine; acupuncture; early intervention services for a *dependent child*, cardiac rehabilitation services, and routine eye care.

Note: Certain *Outpatient* services may be listed as "covered in full" in the table below. If so, you may be charged [the *Deductible* (if applicable) and] an Office Visit *Copayment* when these services are provided along with an office visit. In addition, please note that in accordance with the Patient Protection and Affordable Care Act (PPACA), certain services are not subject to a *Cost Sharing Amount* . Please see the following Benefit Overview chart for more information.

Benefit Overview, continued

MEDICAL OUT-OF-POCKET MAXIMUM

The Medical *Out-of-Pocket Maximum* is limited to the maximum dollar amount as defined each year by the Internal Revenue Service. For more information, see the definition of "*Out-of-Pocket Maximum"* in Appendix A.

The amount of the Medical *Out-of-Pocket Maximum* for you and the enrolled members of your family (if applicable) each c*ontract year* is:
Family Size Medical*Out-of-Pocket Maximum Amount*
• One Member.....$ 5,000 per person.
• Two Members or more.....$10,000 per family.

***Medical Out-of-Pocket Maximum* (Individual)**
This certificate of coverage has an individual Medical *Out-of-Pocket Maximum* of $5,000 per *Member* per *Contract Year* for all *Covered Services.* Only *Copayments* , Deductibles and *Coinsurance* counts toward the Medical *Out-of-Pocket Maximum.* For more information , see the definition of *"Out-of-Pocket Maximum*" in Appendix A.

Medical *Out-of-Pocket Maximum* - (Family*)]*
The Family Medical *Out-of-Pocket Maximum* is satisfied in *Contract Year* when enrolled *Members* in a family each meet their $5,000 Individual Medical *Out-of-Pocket Maximum*.]
The Family Medical *Out-of-Pocket Maximum* is satisfied in a *Contract Year* when:
• one enrolled *Member* in family meets his or her $5,000 Individual *Out-of-Pocket Maximum*; **and**
• one or more additional enrolled *Members* in that family have paid toward their Individual Medical *Out-of-Pocket Maximum* a collective amount equal to the remaining balance of the Family Medical *Out-of-Pocket Maximum.*
All amounts any enrolled *Members* in a family pay toward their Individual *Out-of-Pocket Maximums* are applied toward the $10,000 Family Medical *Out-of-Pocket Maximum*. Once the Family *Out-of-Pocket Maximum* has been met during a *Contract Year*, all enrolled *Members* in a family will thereafter have satisfied their Individual Medical *Out-of-Pocket Maximums* for the remainder of that *Contract Year.*

Pharmacy *OUT-OF-POCKET MAXIMUM*

This certificate of coverage has an individual Pharmacy *Out-of-Pocket Maximum* of $1,000 per *Member* per *Contract Year* for all *Covered Services.* Only *Copayments* , Deductibles and *Coinsurance* counts toward the Pharmacy *Out-of-Pocket Maximum.* For more information , see the definition of *"Out-of-Pocket Maximum*" in Appendix A.

***Pharmacy Out-of-Pocket Maximum* (Individual)**
The amount of the Pharmacy *Out-of-Pocket Maximum* for you and the enrolled members of your family (if applicable) each c*ontract year* is:
Family Size Pharmacy*Out-of-Pocket Maximum Amount*
• One Member.....$1,000 per person.
• Two Members or more.....$2,000 per family.

Benefit Overview, continued

Pharmacy *Out-of-Pocket Maximum* - (Family*)*
The Family Pharmacy *Out-of-Pocket Maximum* is satisfied in *Contract Year* when enrolled *Members* in a family each meet their $1,000 Individual Pharmacy *Out-of-Pocket Maximum*.
The Family Pharmacy *Out-of-Pocket Maximum* is satisfied in a *Contract Year* when:
• one enrolled *Member* in family meets his or her $1,000 Individual *Out-of-Pocket Maximum*; **and**
• one or more additional enrolled *Members* in that family have paid toward their Individual Pharmacy *Out-of-Pocket Maximum* a collective amount equal to the remaining balance of the Family Pharmacy *Out-of-Pocket Maximum.*
All amounts any enrolled *Members* in a family pay toward their Individual *Out-of-Pocket Maximums* are applied toward the $2,000 Family Pharmacy *Out-of-Pocket Maximum*. Once the Family *Out-of-Pocket Maximum* has been met during a *Contract Year*, all enrolled *Members* in a family will thereafter have satisfied their Individual Pharmacy *Out-of-Pocket Maximums* for the remainder of that *Contract Year.*

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	Your Cost	Page

Emergency Care		
Treatment in an Emergency Room	*Copayment* per visit applies. (Waived if admitted as an *Inpatient* or for *Day Surgery*)] **[Note:** *Observation* services will not take an *Emergency* room *Copayment*.]	38
Treatment in a *Provider's* office	Care from a Neighborhood provider *Copayment* per visit applies	38
A *Member* should call *Neighborhood Health Plan* within 48 hours after *Emergency* Care is received. If you are admitted as an *Inpatient*, we recommend that you or someone acting for you call your *PCP* or *Neighborhood Health Plan* within 48 hours. A *Day Surgery Copayment* may apply if *Day Surgery* services are received.		
***Outpatient* Care**		
Allergy Testing **(PA)**	Deductible and coinsurance apply; no copayments apply .	38
Cardiac rehabilitation] **(PA) (BL)**	Deductible and coinsurance apply; no copayments apply .	38
Chemotherapy	*Deductible* and c*oinsurance apply*.	38
Chiropractic **(BL), (PA)**	*Deductible* and c*oinsurance apply*.	38
Contraceptive Services	*Deductible* and c*oinsurance apply*.	39
Diabetes Services and Supplies **(PA)**	Diabetic test strips: *Deductible* and c*oinsurance apply*. Diabetes self-management education: *Deductible* and c*oinsurance apply*. Diabetes supplies covered as *Durable Pharmacy Equipment*: *Deductible* applies Diabetes supplies covered as pharmacy supplies: *Deductible* applies For information about your cost for diabetes supplies covered as prescription medication, see "Prescription Drug Benefit" in Chapter 4.	39

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	Your Cost	Page
***Outpatient* Care, continued**		
Diagnostic Imaging **(PA)**	**Office Visit**: *Deductible* and c*oinsurance apply*.. ***Day Surgery****; Deductible* and c*oinsurance apply*. *Surgery* admission to a *Hospital* [*This *Copayment* also applies for *Covered Day Surgery* services at a free- standing surgical center.] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	40
Early Intervention Services **(PA), (BL)**	Deductible and coinsurance apply; no copayments apply .	41
Hemodialysis services]	Deductible and coinsurance apply; no copayments apply .	41
Human leukocyte antigen testing or histocompatibility locus antigen testing **(PA)(BL)**	Deductible and coinsurance apply; no copayments apply .	41
Immunizations	*No deductible, coinsurance or* c*opayment apply*.	41
Infertility services **(PA), (BL)**	Deductible and coinsurance apply; no copayments apply .	42
Laboratory tests **(PA)**	Deductible and coinsurance apply; no copayments apply .	42

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	Your Cost	Page

***Outpatient* Care, continued**		
Lead screenings	Deductible and coinsurance apply; no copayments apply .	43
Lyme disease	Deductible and coinsurance apply; no copayments apply .	43
Nutritional counseling **(PA)**	Deductible and coinsurance apply; no copayments apply .	
Oral health services **(PA)**	Deductible and coinsurance apply; no copayments apply .	
Outpatient free standing ambulatory surgi-center	Deductible and coinsurance apply; no copayments apply .	
Outpatient surgery in a physicians office **(PA)**	Deductible and coinsurance apply; no copayments apply .	
Podiatric services	*Copayment only applies*.	

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Benefit Overview, continued
Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	**Your Cost**	**Page**

Preventive care	*No deductible, coinsurance or* co*payment apply* .	
Hearing examinations and screenings	Deductible and coinsurance apply; no copayments apply .	
Prevention and early detection services **(BL)**	*No deductible, coinsurance or* co*payment apply*	
Radiation Therapy	Deductible and coinsurance apply; no copayments apply	
Respiratory therapy or pulmonary rehabilitation services **(PA)**	No deductible; copayment per visit applies.	
Short term speech, physical and occupational therapy **(PA)**	No deductible; copayment per visit applies.	
Smoking cessation counseling sessions	No deductible; copayment per visit applies.	
Vision care **(PA), (BL)**	No deductible; copayment per visit applies	

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

2014 Certificate of Coverage for Neighborhood Health Plan of Rhode Island
Exchange Health Plan – Individual Market – Silver Level

Covered Service	Your Cost	Page
Inpatient care		
Hospital services **(PA)**	Deductible and coinsurance apply; no copayments apply	
Reconstructive surgery and procedures and mastectomy surgeries **(PA)**	Deductible and coinsurance apply; no copayments apply	
Skilled care in a nursing facility **(PA)**	Deductible and coinsurance apply; no copayments apply	
Solid organ and hematopietic stem cell transplants **(PA)**	Deductible and coinsurance apply; no copayments apply	
Maternity Care		
Maternity care – Outpatient **(PA)**	Deductible and coinsurance apply; no copayments apply	
Maternity care – Inpatient **(PA)**	Deductible and coinsurance apply; no copayments apply	

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	Your Cost	Page
Behavioral Health Services for Mental Health Care		
Outpatient mental health care services **(PA)** required after the initial 12 encounters are used in a calendar year	Deductible and coinsurance apply; no copayments apply	
Inpatient and intermediate mental health care services **(PA)**	Deductible and coinsurance apply; no copayments apply	
Behavioral Health Services for Chemical Dependency		
Outpatient chemical dependency services **(PA)** required after the initial 12 encounters are used in a calendar year	Deductible and coinsurance apply; no copayments apply	
Inpatient and intermediate chemical dependency services **(PA)**	Deductible and coinsurance apply; no copayments apply	
Other Health Services		
Ambulance services **(PA)**	Deductible and coinsurance apply; no copayments apply	
Clinical trials **(PA)**	Deductible and coinsurance apply; no copayments apply	

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Benefit Overview, continued
Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	Your Cost	Page
Other health services continued		
Durable medical equipment **(PA)**	Deductible and coinsurance apply; no copayments apply	
Hearing aids **(PA), (BL)**	Deductible and coinsurance apply; no copayments apply	
Home health care **(PA)**	Deductible and coinsurance apply; no copayments apply	
Hospice care services **(PA)**	Deductible and coinsurance apply; no copayments apply	
Injectable, infused or inhaled medications **(PA)**	Deductible and coinsurance apply; no copayments apply	
Medical supplies **(PA)**	Deductible and coinsurance apply; no copayments apply	
New cancer therapies or other life threatening diseases or conditions **(PA)**	Deductible and coinsurance apply; no copayments apply	
Orthoses and prosthetic devices **(PA), (BL)**	Deductible and coinsurance apply; no copayments apply	
Special medical formulas **(PA)**	Deductible and coinsurance apply; no copayments apply	

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Benefit Overview

This table provides basic information about your benefits under this plan. See "Benefit Limits"and Chapter 4 for detailed explanations of *Covered Services*. This includes certain benefitrestrictions and limitations (for example, visit, day, and dollar maximums).

MEDICAL DEDUCTIBLE

The *Deductible* is the amount you and the enrolled *Members* of your family (if applicable) must pay each year for certain *Covered Services* before payments are made under this certificate of coverage.

Individual Medical *Deductible*.....$2,000 per *Contract Year*
Family Medical *Deductible* .....$4,000 per *Contract Year*

This Family Medical *Deductible* applies for all enrolled *Members* of a family. All amounts any enrolled *Members* in a family pay toward their Individual *Deductibles* are applied toward the Family *Deductible*.
The Family Medical *Deductible* is satisfied in a *Contract Year* when:
•one enrolled *Member* in family meets his or her $2,000 Individual *Deductible*; **and**
•one or more additional enrolled *Members* in that family have paid toward their Individual Medical *Deductibles* a collective amount equal to the remaining balance of the family deductible in any combination. Once the Family Medical *Deductible* has been met during a *Contract Year*, all enrolled *Members* in a family will thereafter have satisfied their Individual *Deductibles* for the remainder of that *Contract Year.*

• The following are not subject to the Medical *Deductible*:
•*Emergency* care;
•Office visits for preventive care*; office visits for family planning; office visits to diagnose and treat illness or injury; mental health and substance abuse services; routine ob/gyn exam; routine eye exam; other vision care from an optometrist; *Outpatient* maternity care (pre-natal and post-partum)**; pediatric dental care; spinal manipulation; chiropractic medicine; acupuncture; nutritional counseling; and health education.
*including diagnostic tests associated with preventive health care, as described in Chapter 4.
**This does not include diagnostic tests such as ultrasounds.
•routine cytological exams (Pap Smears);
•early intervention services for a *Dependent Child;*
•preventive immunizations;
•routine mammograms;
•prostate and colorectal exams;
•Any amounts you pay for prescription drugs. A separate *Deductible* applies to your prescription drug coverage. For more information, see "Prescription Drug Benefit" in Chapter 4.
•Any amount you pay for services, supplies, or medications that are not *Covered Services*.
• Once you meet your *Deductible* in a *Contract Year* for *Covered Services*, you pay only the following:
•Office visit *Copayment* for *Covered Services* not subject to the *Deductible*.
•Emergency room *Copayment*;
•Inpatient Services *Copayment*.
•Day Surgery *Copayment*.
•*Coinsurance*.

Benefit Overview, continued

PHARMACY *DEDUCTIBLE*
The Pharmacy *Deductible* is the amount you and the enrolled *Members* of your family (if applicable) must pay each year for certain *Covered Pharmacy Services* before payments are made under this certificate of c*overage*.

Individual Pharmacy *Deductible*..... $100 per *Contract Year*
Family Pharmacy *Deductible* ….....$200 per *Contract Year*]

This Family Pharmacy *Deductible* applies for all enrolled *Members* of a family.
All amounts any enrolled *Members* in a family pay toward their Individual *Deductibles* are applied toward the Family Pharmacy *Deductible*.
The Family *Deductible* is satisfied in a *Contract Year* when:
•one enrolled *Member* in family meets his or her $250 Individual *Deductible*; **and**
•one or more additional enrolled *Members* in that family have paid toward their Individual *Deductibles* a collective amount equal to the remaining balance of the family deductible in any combination.
Once the Family *Deductible* has been met during a *Contract Year*, all enrolled *Members* in a family will thereafter have satisfied their Individual *Deductibles* for the remainder of that *Contract Year*.

COINSURANCE
Except as described in the "Benefit Overview" table below, the *Member* pays 20% after the deductible is satisfied of the *Reasonable Charge* for certain *Covered Services*. The *Member* is also responsible for any charges in excess of the *Reasonable Charge*.

COPAYMENTS
• ***Emergency* Care:**
• Emergency room.....$100 *Copayment* per visit
• In *Provider's* office .....$10 *Copayment* per visit for care received from a Neighborhood provider.
[Note[s]:
• An Emergency Room *Copayment* may apply if you register in an Emergency room but leave that facility without receiving care.]
• A *Day Surgery Copayment* may apply if *Day Surgery* services are received.
• Urgent Care .. $20 *Copayment* varies depending on type of *Provider* (*PCP* or Specialist) and location in which service is rendered (for example, *Emergency Room,* urgent care center, or physician's office).per visit
•Other *Covered Services*:
• Office Visit.....$20 - *Copayment* per visit for office visits.

Note: This *Copayment* applies to covered *Outpatient* care provided by your *PCP*, amental health/substance abuse *Provider*, or an obstetrician/ gynecologist ("Ob/Gyn"),as well as for *Outpatient* - physical, occupational, or speech therapy services, spinal manipulation, chiropractic medicine; acupuncture; early intervention services for a *dependent child*, cardiac rehabilitation services, and routine eye care.

Note: Certain *Outpatient* services may be listed as "covered in full" in the table below. If so, you may be charged [the *Deductible* (if applicable) and] an Office Visit *Copayment* when these services are provided along with an office visit. In addition, please note that in accordance with the Patient Protection and Affordable Care Act (PPACA), certain services are not subject to a *Cost Sharing Amount* . Please see the following Benefit Overview chart for more information.

Benefit Overview, continued

MEDICAL OUT-OF-POCKET MAXIMUM

The Medical *Out-of-Pocket Maximum* is limited to the maximum dollar amount as defined each year by the Internal Revenue Service. For more information, see the definition of "*Out-of-Pocket Maximum"* in Appendix A.

The amount of the Medical *Out-of-Pocket Maximum* for you and the enrolled members of your family (if applicable) each c*ontract year* is:
Family Size Medical*Out-of-Pocket Maximum Amount*
• One Member.....$4,000 per person.
• Two Members or more.....$8,000 per family.

***Medical Out-of-Pocket Maximum* (Individual)**
This certificate of coverage has an individual Medical *Out-of-Pocket Maximum* of $4,000 per *Member* per *Contract Year* for all *Covered Services.* Only *Copayments* , Deductibles and *Coinsurance* counts toward the Medical *Out-of-Pocket Maximum.* For more information , see the definition of *"Out-of-Pocket Maximum*" in Appendix A.

Medical *Out-of-Pocket Maximum* - (Family*)]*
The Family Medical *Out-of-Pocket Maximum* is satisfied in *Contract Year* when enrolled *Members* in a family each meet their $4,000 Individual Medical *Out-of-Pocket Maximum*.]
The Family Medical *Out-of-Pocket Maximum* is satisfied in a *Contract Year* when:
• one enrolled *Member* in family meets his or her $4,000 Individual *Out-of-Pocket Maximum*; **and**
• one or more additional enrolled *Members* in that family have paid toward their Individual Medical *Out-of-Pocket Maximum* a collective amount equal to the remaining balance of the Family Medical *Out-of-Pocket Maximum.*
All amounts any enrolled *Members* in a family pay toward their Individual *Out-of-Pocket Maximums* are applied toward the $8,000 Family Medical *Out-of-Pocket Maximum*. Once the Family *Out-of-Pocket Maximum* has been met during a *Contract Year*, all enrolled *Members* in a family will thereafter have satisfied their Individual Medical *Out-of-Pocket Maximums* for the remainder of that *Contract Year.*

Pharmacy *OUT-OF-POCKET MAXIMUM*

This certificate of coverage has an individual Pharmacy *Out-of-Pocket Maximum* of $500 per *Member* per *Contract Year* for all *Covered Services.* Only *Copayments* , Deductibles and *Coinsurance* counts toward the Pharmacy *Out-of-Pocket Maximum.* For more information , see the definition of *"Out-of-Pocket Maximum*" in Appendix A.

The amount of the Pharmacy *Out-of-Pocket Maximum* for you and the enrolled members of your family (if applicable) each contract year is:
Family Size Pharmacy*Out-of-Pocket Maximum Amount*
• One Member.....$500 per person.
• Two Members or more.....$1,000 per family.

Benefit Overview, continued

Pharmacy *Out-of-Pocket Maximum* - (Family*)*
The Family Pharmacy *Out-of-Pocket Maximum* is satisfied in *Contract Year* when enrolled *Members* in a family each meet their $500 Individual Pharmacy *Out-of-Pocket Maximum*.
The Family Pharmacy *Out-of-Pocket Maximum* is satisfied in a *Contract Year* when:
• one enrolled *Member* in family meets his or her $500 Individual *Out-of-Pocket Maximum*; **and**
• one or more additional enrolled *Members* in that family have paid toward their Individual Pharmacy *Out-of-Pocket Maximum* a collective amount equal to the remaining balance of the Family Pharmacy *Out-of-Pocket Maximum.*
All amounts any enrolled *Members* in a family pay toward their Individual *Out-of-Pocket Maximums* are applied toward the $1,000 Family Pharmacy *Out-of-Pocket Maximum*. Once the Family *Out-of-Pocket Maximum* has been met during a *Contract Year*, all enrolled *Members* in a family will thereafter have satisfied their Individual Pharmacy *Out-of-Pocket Maximums* for the remainder of that *Contract Year.*

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	**Your Cost**	**Page**
Emergency Care		
Treatment in an Emergency Room	*Copayment* per visit applies. (Waived if admitted as an *Inpatient* or for *Day Surgery*)] **[Note:** *Observation* services will not take an *Emergency* room *Copayment*.]	38
Treatment in a *Provider's* office	Care from a Neighborhood provider *Copayment* per visit applies	38
A *Member* should call *Neighborhood Health Plan* within 48 hours after *Emergency* Care is received. If you are admitted as an *Inpatient*, we recommend that you or someone acting for you call your *PCP* or *Neighborhood Health Plan* within 48 hours. A *Day Surgery Copayment* may apply if *Day Surgery* services are received.		
***Outpatient* Care**		
Allergy Testing **(PA)**	Deductible and coinsurance apply; no copayments apply .	38
Cardiac rehabilitation] **(PA) (BL)**	Deductible and coinsurance apply; no copayments apply .	38
Chemotherapy	*Deductible* and c*oinsurance apply*.	38
Chiropractic **(BL), (PA)**	*Deductible* and c*oinsurance apply*.	38
Contraceptive Services	*Deductible* and c*oinsurance apply*.	39
Diabetes Services and Supplies **(PA)**	Diabetic test strips: *Deductible* and c*oinsurance apply*. Diabetes self-management education: *Deductible* and c*oinsurance apply*. Diabetes supplies covered as *Durable Pharmacy Equipment*: *Deductible* applies Diabetes supplies covered as pharmacy supplies: *Deductible* applies For information about your cost for diabetes supplies covered as prescription medication, see "Prescription Drug Benefit" in Chapter 4.	39

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	**Your Cost**	**Page**
***Outpatient* Care, continued**		
Diagnostic Imaging **(PA)**	**Office Visit**: *Deductible* and c*oinsurance apply*.. ***Day Surgery****; Deductible* and c*oinsurance apply*. *Surgery* admission to a *Hospital* [*This *Copayment* also applies for *Covered Day Surgery* services at a free- standing surgical center.] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	40
Early Intervention Services **(PA), (BL)**	Deductible and coinsurance apply; no copayments apply .	41
Hemodialysis services]	Deductible and coinsurance apply; no copayments apply .	41
Human leukocyte antigen testing or histocompatibility locus antigen testing **(PA)(BL)**	Deductible and coinsurance apply; no copayments apply .	41
Immunizations	*No deductible, coinsurance or* c*opayment apply*.	41
Infertility services **(PA), (BL)**	Deductible and coinsurance apply; no copayments apply .	42
Laboratory tests **(PA)**	Deductible and coinsurance apply; no copayments apply .	42

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	**Your Cost**	**Page**
***Outpatient* Care, continued**		
Lead screenings	Deductible and coinsurance apply; no copayments apply .	43
Lyme disease	Deductible and coinsurance apply; no copayments apply .	43
Nutritional counseling **(PA)**	Deductible and coinsurance apply; no copayments apply .	43
Oral health services **(PA)**	Deductible and coinsurance apply; no copayments apply .	43
Outpatient free standing ambulatory surgi-center	Deductible and coinsurance apply; no copayments apply .	44
Outpatient surgery in a physicians office **(PA)**	Deductible and coinsurance apply; no copayments apply .	44
Podiatric services	*Copayment only applies*.	44

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	**Your Cost**	**Page**
Preventive care	*No deductible, coinsurance or* co*payment apply* .	44
Hearing examinations and screenings	Deductible and coinsurance apply; no copayments apply .	45
Prevention and early detection services **(BL)**	*No deductible, coinsurance or* co*payment apply*	45
Radiation Therapy	Deductible and coinsurance apply; no copayments apply	46
Respiratory therapy or pulmonary rehabilitation services **(PA)**	No deductible; copayment per visit applies.	46
Short term speech, physical and occupational therapy **(PA)**	No deductible; copayment per visit applies.	46
Smoking cessation counseling sessions	No deductible; copayment per visit applies.	46
Vision care **(PA), (BL)**	No deductible; copayment per visit applies	47

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	**Your Cost**	**Page**
Inpatient care		
Hospital services **(PA)**	Deductible and coinsurance apply; no copayments apply	50
Reconstructive surgery and procedures and mastectomy surgeries **(PA)**	Deductible and coinsurance apply; no copayments apply	50
Skilled care in a nursing facility **(PA)**	Deductible and coinsurance apply; no copayments apply	51
Solid organ and hematopietic stem cell transplants **(PA)**	Deductible and coinsurance apply; no copayments apply	51
Maternity Care		
Maternity care – Outpatient **(PA)**	Deductible and coinsurance apply; no copayments apply	52
Maternity care – Inpatient **(PA)**	Deductible and coinsurance apply; no copayments apply	52

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	Your Cost	Page
Behavioral Health Services for Mental Health Care		
Outpatient mental health care services **(PA)** required after the initial 12 encounters are used in a calendar year	Deductible and coinsurance apply; no copayments apply	53
Inpatient and intermediate mental health care services **(PA)**	Deductible and coinsurance apply; no copayments apply	55
Behavioral Health Services for Chemical Dependency		
Outpatient chemical dependency services **(PA)** required after the initial 12 encounters are used in a calendar year	Deductible and coinsurance apply; no copayments apply	55
Inpatient and intermediate chemical dependency services **(PA)**	Deductible and coinsurance apply; no copayments apply	55
Other Health Services		
Ambulance services **(PA)**	Deductible and coinsurance apply; no copayments apply	56
Clinical trials **(PA)**	Deductible and coinsurance apply; no copayments apply	56

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.
(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. See *Benefit Limits* and Chapter 4 for detailed explanations of Covered Services. This includes certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

Covered Service	**Your Cost**	**Page**
Other health services continued		
Durable medical equipment **(PA)**	Deductible and coinsurance apply; no copayments apply	57
Hearing aids **(PA), (BL)**	Deductible and coinsurance apply; no copayments apply	58
Home health care **(PA)**	Deductible and coinsurance apply; no copayments apply	58
Hospice care services **(PA)**	Deductible and coinsurance apply; no copayments apply	59
Injectable, infused or inhaled medications **(PA)**	Deductible and coinsurance apply; no copayments apply	59
Medical supplies **(PA)**	Deductible and coinsurance apply; no copayments apply	60
New cancer therapies or other life threatening diseases or conditions **(PA)**	Deductible and coinsurance apply; no copayments apply	60
Orthoses and prosthetic devices **(PA), (BL)**	Deductible and coinsurance apply; no copayments apply	60
Special medical formulas **(PA)**	Deductible and coinsurance apply; no copayments apply	60

(PA) –*Prior authorization* is required for these services. See Chapter 3; Section 1.3 for more information.

(BL) –Benefit Limit applies. See "*Covered Services*" in Chapter 4 for more information.

2014 Certificate of Coverage for Neighborhood Health Plan of Rhode Island
Exchange Health Plan – Individual Market – Gold Level

SERFF Tracking #:	*NHRI-128972321*	***State Tracking #:***		***Company Tracking #:***	*NHPRI - INDIVIDUAL MARKET - 2*

State:	*Rhode Island*	***Filing Company:***	*Neighborhood Health Plan of Rhode Island*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*Neighborhood - Individual Market Product*		
Project Name/Number:	*NHPRI Health Exchange 2014 - Individual Market/NHPRI Individual Market 2*		

Rate Information

Rate data applies to filing.

Filing Method:	file and use
Rate Change Type:	Neutral
Overall Percentage of Last Rate Revision:	0.000%
Effective Date of Last Rate Revision:	01/01/2013
Filing Method of Last Filing:	NA

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Neighborhood Health Plan of Rhode Island	New Product	0.000%	0.000%	$0	0	$0	0.000%	0.000%

Product Type:	HMO	PPO	EPO	POS	HSA	HDHP	FFS	Other
Covered Lives:								
Policy Holders:								

State: Rhode Island **Filing Company:** Neighborhood Health Plan of Rhode Island
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: Neighborhood - Individual Market Product
Project Name/Number: NHPRI Health Exchange 2014 - Individual Market/NHPRI Individual Market 2

Rate Review Detail

COMPANY:

Company Name: Neighborhood Health Plan of Rhode Island
HHS Issuer Id: 77514
Product Names: Neighborhood - Individual Market Product
Trend Factors:

FORMS:

New Policy Forms: Yes
Affected Forms: NA
Other Affected Forms: NA

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
Member Months: 68,511
Benefit Change:
Percent Change Requested: Min: Max: Avg:

PRIOR RATE:

Total Earned Premium:
Total Incurred Claims:
Annual $: Min: Max: Avg:

REQUESTED RATE:

Projected Earned Premium: 26,480,701.00
Projected Incurred Claims: 21,583,222.00
Annual $: Min: 386.52 Max: 386.52 Avg: 386.52

Supporting Document Schedules

Bypassed - Item:	A&H Experience
Bypass Reason:	New Plans - There is no experience at this time.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Certification - Life & A&H
Comments:	
Attachment(s):	Actuarial Certification - NHPRI - Individual.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum - Life & A&H
Comments:	These requirements appear in 2 sections and have been added to both to insure compliance.
Attachment(s):	Actuarial Certification - NHPRI - Individual.pdf 08-Actuarial Memorandums - NHPRI Exchange Products - Individual Products .pdf
Item Status:	
Status Date:	

Bypassed - Item:	Actuarial Memorandum - A&H Rate Revision Filing
Bypass Reason:	Not a revision filing
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Premium Rate Sheets - Life & A&H
Comments:	
Attachment(s):	Rates Data Template - Individual.zip
Item Status:	
Status Date:	

State: Rhode Island **Filing Company:** Neighborhood Health Plan of Rhode Island
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: Neighborhood - Individual Market Product
Project Name/Number: NHPRI Health Exchange 2014 - Individual Market/NHPRI Individual Market 2

Satisfied - Item:	Health Insurance Checklist
Comments:	
Attachment(s):	Non Group Insurance Checklist.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Bulletin 2010-3 with Readability Certification
Comments:	
Attachment(s):	Readability Certification - Submission Copy.pdf
Item Status:	
Status Date:	

Satisfied - Item:	PPACA Uniform Compliance Summary
Comments:	
Attachment(s):	PPACA Uniform Compliance Summary-Individual Market - Submission Copy.pdf
Item Status:	
Status Date:	

Satisfied - Item:	2013 Form Review Process Individual and Small Group Plans Checklist
Comments:	
Attachment(s):	NHPRI Exchange Product - Individual Market - Reg 17 Checklist - 4-15 Submission Copy.pdf NHPRI Exchange Product - Individual Market - Reg 17 Checklist - 4-15 Submission Copy.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	Actuarial Certification - NHPRI - Individual.pdf 08-Actuarial Memorandums - NHPRI Exchange Products - Individual Products .pdf
Item Status:	
Status Date:	

Satisfied - Item:	2013 Form Review Process Issuer and Plan Compliance Attestation

State: Rhode Island **Filing Company:** Neighborhood Health Plan of Rhode Island
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: Neighborhood - Individual Market Product
Project Name/Number: NHPRI Health Exchange 2014 - Individual Market/NHPRI Individual Market 2

Comments:	
Attachment(s):	Individual Mkt Form Attestation - March 1, 2013.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	Note - Since NHPRI has not been in the Individual Market previously, experience sections have not been completed.
Attachment(s):	Part I Unified Rate Review Template - NHPRI - Individual.xlsm
Item Status:	
Status Date:	

Bypassed - Item:	Consumer Disclosure Form
Bypass Reason:	Not yet available
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	HEALTH Revised Network Adequacy Process Letter
Bypass Reason:	Not a submission requirement
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Regulation 17
Comments:	Updated for new CoC submitted on 5-8-13
Attachment(s):	NHPRI Exchange Product - Individual Market - Reg 17 Checklist - (submission copy).pdf
Item Status:	
Status Date:	

Satisfied - Item:	2013 Rate Review Process Issuer and Plan Compliance Attestation
Comments:	
Attachment(s):	Individual Mkt Rate Attestation - April 15, 2013.pdf

State: Rhode Island **Filing Company:** Neighborhood Health Plan of Rhode Island
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: Neighborhood - Individual Market Product
Project Name/Number: NHPRI Health Exchange 2014 - Individual Market/NHPRI Individual Market 2

Item Status:	
Status Date:	

Satisfied - Item:	2013 Rate Review Process OHIC Template
Comments:	
Attachment(s):	2013 Rate Review Process OHIC Template - NHPRI - Individual.xlsx 2013 Rate Review Process OHIC Template - NHPRI - Individual.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Federal Administration Form
Comments:	
Attachment(s):	Plan_management_data_templates_administrative - 2013.xls
Item Status:	
Status Date:	

Satisfied - Item:	Federal ECP Form
Comments:	
Attachment(s):	Plan_management_data_templates_ecp.xls
Item Status:	
Status Date:	

Satisfied - Item:	Federal NCQA Accreditation Form
Comments:	
Attachment(s):	plan_management_data_templates_issuer_ncqa - Individual Market.xls
Item Status:	
Status Date:	

Satisfied - Item:	Part II - Consumer Narrative Justification
Comments:	
Attachment(s):	Part II - Consumer Narrative Justification - NHPRI Exchange Individual Product.pdf
Item Status:	
Status Date:	

State: Rhode Island **Filing Company:** Neighborhood Health Plan of Rhode Island
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: Neighborhood - Individual Market Product
Project Name/Number: NHPRI Health Exchange 2014 - Individual Market/NHPRI Individual Market 2

Satisfied - Item:	AV Calculators
Comments:	Attached are AV Calculators for Individual and SHOP
Attachment(s):	AV Calculator - NHPRI FINAL Plan Designs.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Provider Network Form
Comments:	Our Network URL has temporarily been pointed to our RiteCare Provider Network. Our Exchange Provider Network is nearly the same and is under construction.
Attachment(s):	Plan_management_data_templates_network.xls
Item Status:	
Status Date:	

Satisfied - Item:	Plans/Benefits Template
Comments:	Our Benefits URLs have been temporarily pointed to our RiteCare Handbook. Our Exchange Benefits are nearly the same and is under construction.
Attachment(s):	Plan_management_data_templates_plans_benefits - Individual Market.xlsm
Item Status:	
Status Date:	

Satisfied - Item:	Prescription Drug Template
Comments:	Our Formulary URL has been temporarily pointed to our RiteCare Formulary. Our Exchange Formulary is under construction.
Attachment(s):	Plan_management_data_templates_prescription_drug.xls NHPRI - Formulary - Inadequate Category Justification.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Service Area Template
Comments:	Attached is our service area template.
Attachment(s):	Plan_management_data_templates_service_area.xls
Item Status:	

SERFF Tracking #:	*NHRI-128972321*	***State Tracking #:***		***Company Tracking #:***	*NHPRI - INDIVIDUAL MARKET - 2*

State:	*Rhode Island*	***Filing Company:***	*Neighborhood Health Plan of Rhode Island*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005C Individual - Other*		
Product Name:	*Neighborhood - Individual Market Product*		
Project Name/Number:	*NHPRI Health Exchange 2014 - Individual Market/NHPRI Individual Market 2*		

Status Date:	

Satisfied - Item:	2013 Rate Review Process OHIC Template - PDF Version
Comments:	2013 Rate Review Process OHIC Template - Individual
Attachment(s):	2013 Rate Review Process OHIC Template - NHPRI - Individual.pdf
Item Status:	
Status Date:	

Attachment Rates Data Template - Individual.zip is not a PDF document and cannot be reproduced here.

Attachment Part I Unified Rate Review Template - NHPRI - Individual.xlsm is not a PDF document and cannot be reproduced here.

Attachment 2013 Rate Review Process OHIC Template - NHPRI - Individual.xlsx is not a PDF document and cannot be reproduced here.

Attachment Plan_management_data_templates_administrative - 2013.xls is not a PDF document and cannot be reproduced here.

Attachment Plan_management_data_templates_ecp.xls is not a PDF document and cannot be reproduced here.

Attachment plan_management_data_templates_issuer_ncqa - Individual Market.xls is not a PDF document and cannot be reproduced here.

Attachment Plan_management_data_templates_network.xls is not a PDF document and cannot be reproduced here.

Attachment Plan_management_data_templates_plans_benefits - Individual Market.xlsm is not a PDF document and cannot be reproduced here.

Attachment Plan_management_data_templates_prescription_drug.xls is not a PDF document and cannot be reproduced here.

Attachment Plan_management_data_templates_service_area.xls is not a PDF document and cannot be reproduced here.

RHODE ISLAND ACTUARIAL CERTIFICATION

Carrier: Neighborhood Health Plan Of Rhode Island

Submission:

Neighborhood - Individual Market Product

I hereby certify that to the best of my knowledge and belief, the above submission conforms to generally accepted actuarial principles, standards and guidelines, that the reserves, including a test of deficiency reserves, and non-forfeiture benefits, if applicable, comply with all statutes, rules and regulations of the state of Rhode Island, and that premiums, if any, are not inadequate, excessive, unfairly discriminatory, or unreasonable in relation to benefits.

Signature of qualified actuary: Jeremy D. Palmer Electronic Signature

Name (typed or printed): Jeremy D. Palmer, FSA, MAAA

Title or business affiliation: Principal & Consulting Actuary, Milliman Inc.

Date: 4/12/2013

A thorough review of the law, bulletins, and the Rating Compliance Guidelines should be made prior to signing this certification.

Reset Form

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Signature of qualified actuary: Jeremy D. Palmer Electronic Signature

Name (typed or printed): Jeremy D. Palmer, FSA, MAAA

Title or business affiliation: Principal & Consulting Actuary, Milliman Inc.

Date: 4/12/2013

A thorough review of the law, bulletins, and the Rating Compliance Guidelines should be made prior to signing this certification.

Reset Form

Milliman

NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND

Individual Market Products
Actuarial Memorandum

I. SCOPE AND PURPOSE

Milliman, Inc. (Milliman) has been retained by Neighborhood Health Plan of Rhode Island (NHPRI) to prepare the premium rates and actuarial memorandum for Individual market products to be offered on the Rhode Island Health Benefit Exchange (RIHBE).

This document contains the Part III Actuarial Memorandum for NHPRI's Individual block of business, effective January 1, 2014. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template. This actuarial memorandum will also serve as the memorandum to support the 2013 Rate Review Process OHIC Template. The memorandum is intended to demonstrate that the premiums for these products are reasonable in relation to the benefits provided and to demonstrate compliance with regulatory authority. This memorandum may not be appropriate for any other purpose.

This actuarial memorandum has been prepared to be included in NHPRI's rate filings and is intended for use by the State of Rhode Island Office of the Health Insurance Commissioner (OHIC), the Rhode Island Health Benefit Exchange (RIHBE), the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of NHPRI's filings. However, we recognize that this certification may become a public document. Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this actuarial memorandum prepared for NHPRI by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

The memorandum does not guarantee that the rates will be adequate. Rather, the filing shows that the rates will be adequate if the assumptions underlying their development are realized.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

II. GENERAL INFORMATION

General Information related to NHPRI and the policies applicable to this actuarial memorandum are made available below.

A. Company Identifying Information

- Company Legal Name: Neighborhood Health Plan of Rhode Island
- State: The State of Rhode Island has regulatory authority over these policies
- HIOS Issuer ID: 77514
- Market: Individual
- Effective Date: January 1, 2014

B. Company Contact Information

- Primary Contact Name: Mr. T. Clark Phillip, CPA, Chief Financial Officer
- Primary Contact Telephone Number: (401) 459-6611
- Primary Contact Email Address: cphillip@nhpri.org

III. PROPOSED RATE INCREASE

Not applicable. The proposed rates within this actuarial memorandum are for new products that are intended to be offered on the RIHBE. NHPRI currently does not offer any products in the commercial health insurance market. As such, there are no rate adjustments being proposed.

IV. EXPERIENCE PERIOD PREMIUM AND CLAIMS

Not applicable. NHPRI currently does not offer any products in the commercial health insurance market. Because of this, no relevant experience based premium and/or claims data is available. The premium rates and corresponding factors proposed in this memorandum are based on a manual rate development process.

V. BENEFIT CATEGORIES

Not applicable. As no relevant data was available for the purpose of developing premium rates, experience data was not summarized by benefit category. The premium rates and corresponding factors proposed in this memorandum are based on a manual rate development process.

VI. PROJECTION FACTORS

Not applicable. Factors were not developed for the purpose of projecting experience period allowed claims, since no experience data was available. The premium rates and corresponding factors proposed in this memorandum are based on a manual rate development process. Assumptions for items such as morbidity changes, demographic changes, and trend were considered in developing manual rates as described in Section VII.

VII. CREDIBILITY MANUAL RATE DEVELOPMENT

NHPRI currently does not offer any products in the commercial health insurance market, which results in no experience data being available. For this reason, the premium rates and corresponding factors proposed in this memorandum are solely based on the manual rate development process.

In order to estimate premium rates for NHPRI products, the following steps were performed. These steps outline the premium development process including Population Assumptions (including morbidity and pent-up demand), Claim Costs, Administrative Expenses, Risk Adjustment Transfer, and Federal Transitional Reinsurance. While some of these items may fall outside of the scope of manual rate development, it is important to understand the process in its entirety.

A. Step 1: Project Statewide Market Members and Health Status by Population Cohort

We anticipate shifts in the insured population when the Rhode Island Health Benefit Exchange opens in 2014. We projected Rhode Island statewide members and their health status to help determine NHPRI's share of the market, the morbidity of their members, and NHPRI's risk adjustment receipts or payments.

For the purpose of projecting Rhode Island membership, a population projection model developed by Milliman's Indianapolis Health Practice was utilized (the Model). This model estimates the calendar year 2011 insurance market population and applies assumptions in order to project the developed population to future years. Estimated insurance market population counts are divided into cohorts that represent a combination of age, gender, household income (measured as percent of the Federal Poverty Level), and self-reported health status. Insurance coverage's incorporated in the model include Medicaid, Medicare, Individual Insured, Small Group Insured, Large Group Insured, Self-Funded, Employer Part-Time, Employer Retiree, and Uninsured. For each type of insurance coverage, enrollment is estimated by percent of Federal Poverty Level, Age, and Gender. Additionally, morbidity assumptions for both the baseline period and projection period are estimated.

The model uses the latest data available from multiple public and proprietary sources in order to understand the current market population by insurance coverage, age, gender, percent of Federal Poverty Level (FPL), health status, and Metropolitan Statistical Area (MSA).

The data utilized by the Model is comprised of public data sources outlined below.

- Current Population Survey (CPS) data – This data, which is updated monthly, provides us with demographic information by insurance coverage, age, FPL, and health status. In order to obtain a credible sample size, CPS data from 2009 through 2011 is summarized. In situations where CPS sample size credibility is a concern, state data is blended with the corresponding HHS regional data to further enhance credibility in modeling results.
- American Community Survey (ACS) data – Because of a larger sample size, ACS data is used in order to provide more accurate enrollment counts by insurance coverage, age, gender, and FPL. This population count data is merged with the CPS data by health status in order to obtain a detailed estimate of the current population.
- MLR data – Publically available 2011 Medical Loss Ratio Reporting Form data (MLR) is used in order to determine the current number of covered lives by insurance segment (Individual, Small Group, Large Group). This data also provides insight on claims and premiums per member per month (PMPM) for these insurance segments.

In addition to the data sources described above, the ***Milliman Health Cost Guidelines™*** (HCG) and ***Milliman Medical Underwriting Guidelines™*** (MUG) are utilized. These sources provide insight into items such as relative claims cost by age, gender, and health status. Pairing the HCG and MUG data with the publicly available data sources enables the Model to produce age/gender and morbidity estimates for the population.

Each of the data sources outlined plays a specific role in understanding the current population. The methodology implemented within the model is outlined below.

- The CPS data is utilized to estimate the percent of the population in Excellent, Very Good, Good, and Fair/Poor Health Status.
- ACS data is utilized to estimate the population breakdown by insurance coverage, age, gender, FPL, health status, and MSA.
- MLR data is used to understand the size of the insured markets (Individual, Small Group, Large Group), along with estimating current market claims PMPM.

The proportion of the population that will purchase coverage on the RIHBE is then estimated (i.e., "take-up"). These take-up rate assumptions are primarily driven by a member's current insurance status (i.e., insured or uninsured) and the federal subsidy available (if any) if the member enrolls in a plan on the RIHBE.

We then applied employer-sponsored insurance transition rates and individual/uninsured RIHBE take-up rates to estimate the population counts in each market (stratified by income-to-poverty ratio, health status, and family size). The result is a 2014 population projection by cohort (i.e., age, gender, income, and exchange status).

B. Step 2: Project NHPRI Enrollment by Market and Exchange Status

NHPRI's expected 2014 Individual enrollment was projected based on our estimate of the statewide population and market share estimates provided by NHPRI. As NHPRI will only be offering products on the RIHBE, it is assumed that no off exchange enrollment will exist. We estimated the members that would select each of NHPRI's benefit plans based on the plans for which they would qualify (given their age and income level). We also assumed that all 2014 members are enrolled for the entire year.

C. Step 3: Project Statewide Risk Scores For Use in the Risk Adjustment Transfer Payment

For the purpose of estimating NHPRI's risk adjustment transfer payment, the population projection model outlined in Step 1 was utilized to project statewide risk scores. This was completed by inferring the health status of the projected insured population by cohort using the self-reported health status field in the CPS data. Relative health status factors for each self-reported health status category, developed based on data available within the MUGs, were inferred based on the proportion of members within each self-reported health status category. These inferred relative health status factors were combined with age/gender claim cost factors from the HCGs to produce final statewide average risk scores for each population cohort.

D. Step 4: Project NHPRI's Risk Score For Use in the Risk Adjustment Transfer Payment

We assumed that NHPRI's risk scores for a given age, gender, and FPL cohort were comparable to the statewide average risk scores for the same cohort. This assumption relies on there being similar Selection and Coding Intensity between NHPRI and the statewide average. Selection refers to the health status difference between a given carrier and the overall market. Coding Intensity refers to a differing frequency and accuracy with which diagnosis codes are captured in claims data impacting the calculated risk score of the population. We did not model the impact of selection between the metal plans because carriers are not permitted to rate for selection.

E. Step 5: Estimate 2014 Statewide Average Claims for the Risk Adjustment Transfer Payments

To estimate the statewide premium in NHPRI's risk adjustment transfer payment, the statewide claim costs were estimated using 2011 Medical Loss Ratio Reporting Form (MLR) data. Blue Cross & Blue Shield of Rhode Island is the predominant carrier in Rhode Island, and as a result, was the focus of this portion of the analysis.

Statewide claim cost PMPM was calculated by adjusting for:

- Trend from 2011 to 2014,
- The pharmacy and device taxes,
- Health status changes due to uninsured individuals entering the insured market,
- Uninsured pent-up demand for medical services,

- Assumed "richness" of the plans and the resulting utilization patterns resulting from a given benefit design level, and
- Additional induced utilization for those enrolling in alternate Silver plans (i.e., those with cost sharing reductions).

When trending figures within the analysis, a consistent annual trend assumption of 5.8% was used for each year.

F. Step 6: Project NHPRI's 2014 Claim Costs

Since no experience is currently available for NHPRI, 2014 claim costs were developed using the ***Milliman Managed Care Rating Model*** (MCRM) and the ***Milliman Prescription Drug Rating Model*** (RXRM). These models were calibrated to reflect cost and utilization levels appropriate for NHPRI's assumed provider contracting arrangements and enrollment characteristics.

Specific considerations included:

- Reflecting NHPRI's assumed 2014 provider reimbursement rates,
- Reflecting NHPRI's assumed utilization rates,
- Adjusting the degree of healthcare management,
- Reflecting NHPRI's plan designs, and
- Reflecting results produced through the population modeling work, including assumptions for morbidity and pent-up demand.

These models were used in order to estimate utilization per 1,000 and average cost per service for the purpose of developing NHPRI's credibility manual. Finally, we projected claim costs PMPM for every combination of age, gender, metal plan, income level, and exchange status.

G. Step 7: Add Administrative Expenses

Administrative expenses were added to NHPRI's claim costs, including:

- General Administrative Expenses,
- Commercial Reinsurance Premium Net of Recoveries,
- Quality Improvement/Information Technology,
- Premium Tax,
- Comparative Effectiveness Research,
- Reinsurance Operating Fee,
- Risk Adjustment Admin Fee, and
- Contribution to Surplus.

Additional details related to administrative expenses can be found in Section XI, Non-Benefit Expenses and Profit & Risk.

H. Step 8: Add Estimated Federal Transitional Reinsurance Expenses

Additional costs or savings due to the Federal transitional reinsurance program were estimated. Differences exist between the markets since only the individual market is eligible for transitional reinsurance. It was assumed that NHPRI would pay $5.25 PMPM in reinsurance contributions. Reinsurance recoveries were estimated under the assumption that the individual market will receive 80% of all individual members' PMPY incurred claims between $60,000 and $250,000.

We estimated this value by calibrating claim probability distributions (CPDs) within the MCRM for each of NHPRI's individual benefit plans estimated PMPM claims.

Additional details related to Federal Transitional Reinsurance can be found in Section X, Risk Adjusters and Reinsurance.

I. Step 9: Estimate NHPRI's Risk Adjustment Transfer Payment

NHPRI's risk adjustment transfer payment was estimated using the CMS formula, which includes the statewide average premium, induced demand factor, geographical cost factor, NHPRI's risk score by plan, the plan's actuarial value, and allowable rating factors. The key determinant of whether NHPRI receives or makes a transfer payment is how NHPRI's risk score (normalized across all carriers) compares to the product of the actuarial value and allowable rating factors (normalized across all carriers).

The statewide average premium was estimated by adding expenses to the statewide average claim costs (i.e., Steps 5 and 7). Next, NHPRI's risk scores were normalized from Step 4 to the statewide average risk score by removing the portion of NHPRIs' risk score that can be accounted for through age rating factors, leaving an "uncompensated risk" factor. We then multiplied the "uncompensated risk" factor by the state average premium PMPM to estimate the net risk adjustment PMPM received or payable by NHPRI.

Additional details related to Risk Adjustment can be found in Section X, Risk Adjusters and Reinsurance.

J. Step 10: Calculate Composite Required Premium

The composite required premium was calculated by summing expected claims, administrative expenses, the net impact of federal reinsurance, and the net impact of state risk adjustment. An additional load was added to account for family policies with more than three members under the age of 21. Lastly, it was verified that no expected minimum loss ratio rebates or risk corridor payments we estimated to result from the established premium rates.

K. Step 11: Calculate Premiums by Rate Cell

The composite required premium was divided by the composite of all allowable rating factors across NHPRI's projected block of business by rating cell to determine a base rate. This base rate, in combination with the allowable rating factors, will result in the premium rates charged to enrollees in 2014.

Age and plan design are the only allowable rating factors for each cohort in Rhode Island. We developed NHPRI's rating factors to meet the regulatory requirements below:

- Age factors as specified by law, and
- Plan factors based on the plan's actuarial value, cost sharing utilization, network, and cost of administration.

VIII. CREDIBILITY OF EXPERIENCE

Since no experience data is available, a credibility assumption of 0% was applied. The manual rates developed through the steps outlined under Section VII are the sole basis for the premium rates proposed in this memorandum.

IX. PAID TO ALLOWED RATIO

The paid to allowed ratio provided in Worksheet 1, Section III of the Unified Rate Review Template (URRT) and in "II Data Collection" of the 2013 Rate Review Process OHIC Template was developed using the MCRM and RXRM models calibrated for the purpose of developing NHPRI's manual rates. These models were used to develop both paid and allowed claims on a per member per month (PMPM) basis for every combination of age, gender, metal plan, income level, and exchange status. The resulting paid and allowed claims PMPM were weighted based on NHPRI's membership projections in order to arrive at an estimated paid to allowed ratio. While utilization differences were considered for the CSR eligible population, the benefits reflected within the paid claim PMPM estimates reflected a silver level of coverage for individuals assumed enrolled in CSR plans.

X. RISK ADJUSTERS AND REINSURANCE

The processes used to estimate risk adjustment and reinsurance were completed in Steps 9 and 8 of the premium development process respectively.

A. Risk Adjustment Transfer Payment Estimate

NHPRI's risk adjustment transfer payment was estimated using the CMS formula, which includes the statewide average premium, induced demand factor, geographical cost factor, NHPRI's risk score by plan, the plan's actuarial value, and allowable rating factors. The key determinant of whether NHPRI receives or makes a transfer payment is how NHPRI's risk score (normalized across all carriers) compares to the product of the actuarial value and allowable rating factors (normalized across all carriers).

The statewide average premium was estimated by adding expenses to the statewide average claim costs produced in the premium development process (Steps 5 and 7). Next, NHPRI's risk scores (from Step 4 of the premium development process) were normalized to the statewide average risk score and the portion of NHPRIs' risk score that can be accounted for through age rating factors was removed; leaving an "uncompensated risk" factor. We then multiplied the "uncompensated risk" factor by the state average premium PMPM to estimate the net risk adjustment PMPM received or payable by NHPRI.

NHPRI's target population in the individual market includes lower income individuals eligible to receive subsidies. It is assumed that lower income individuals have a higher risk compared to higher income individuals. With this in mind, we are estimating NHPRI to receive risk adjustment payments. The estimated PMPM risk adjustment received by NHPRI was aggregated in order to determine the appropriate impact as a percent of premium. The process resulted in an estimated risk adjustment premium impact of approximately -3% (-$11.06 PMPM). Premium rates developed for NHPRI were thus reduced by this percentage in order to appropriately reflect the estimated risk adjustment transfers.

B. Federal Transitional Reinsurance Estimate

Additional costs or savings due to the Federal transitional reinsurance program were estimated. Differences exist between the markets since only the individual market is eligible for transitional reinsurance. It was assumed that NHPRI would pay $5.25 PMPM in reinsurance contributions. Reinsurance recoveries were estimated under the assumption that the individual market will receive 80% of all individual members' PMPY incurred claims between $60,000 and $250,000.

We estimated this value by calibrating claim probability distributions (CPDs) within the MCRM for each of NHPRI's individual benefit plans estimated PMPM claims.

This calculation was performed separately for each combination of age, gender, metal plan, income level, and exchange status. In order to appropriately allocate estimated reinsurance payments, the PMPM results were aggregated to estimate the impact as a percent of premium. Before reflecting reinsurance contributions, Federal transitional reinsurance resulted in an approximately 10% reduction to premium (-$39.27 PMPM). This figure drops to approximately 9% (-$34.02 PMPM) after reflecting the contributions NHPRI is estimated to pay.

XI. NON-BENEFIT EXPENSES AND PROFIT & RISK

The proposed rates reflect an administrative load of approximately 20% including General Administrative Expenses, Contribution to Surplus, Taxes and Fees. This load was developed through the use of assumptions provided to Milliman from NHPRI.

A. Administrative Expense Load

The table below outlines the Administrative Expenses that are reflected in the proposed premium rates. These expenses were developed using assumptions provided to Milliman from NHPRI. All categories are demonstrated as both a PMPM and percent of premium. However, please note that some items were developed and applied on a different basis. In these situations, items have been converted to PMPM equivalents or Percent of Premium equivalents as needed for illustrative purposes.

Table 1: Administrative Expenses

Description	PMPM Equivalent	Percent of Premium
General Administrative Expense	$ 39.35	10.2%
Commercial Reinsurance Net of Recoveries	$ 1.75	0.5%
Quality Improvement	$ 7.20	1.9%
Additional Child Load	$ 3.50	0.9%

NHPRI will not be paying any broker commissions and, as such, administrative expenses associated with commissions are not reflected. The Additional Child Load is intended to reflect that rates for family policies cannot account for more than three members under the age of 21. A portion of this load will be reflected in claims experience in subsequent years (approximately 0.7%), while the remaining portion is intended to account for additional administrative expenses associated with these members.

B. Contribution to Surplus & Risk margin

The proposed rates reflect 3% of premium being allocated to Contribution to Surplus & Risk Margin. This load was applied evenly to all plans being offered by NHPRI.

C. Taxes and Fees

The table below outlines the Taxes and Fees that are included in the non-benefit expenses.

Table 2: Taxes and Fees

Description	PMPM Equivalent	Percent of Premium
Premium Tax	$ 7.73	2.00%
Comparative Effectiveness Research	$ 0.17	0.04%
Reinsurance Operating Fee	$ 0.11	0.03%
Risk Adjustment Admin Fee	$ 0.08	0.02%

It is currently understood that there will be no Exchange Operation Fees in Rhode Island for calendar year 2014. Additionally, it is assumed that NHPRI will not be assessed the Health Insurer Tax provided that over 80% of premiums are received for Medicaid.

XII. PROJECTED LOSS RATIO

The projected loss ratio for NHPRI's Individual bock of business is approximately 86.7%. This loss ratio is calculated consistently with the Federally prescribed MLR methodology, and reflects the projected loss ratio prior to reflecting any applicable credibility adjustments. A credibility adjusted loss ratio is estimated at approximately 91.0% based on membership projections developed by Milliman with guidance from NHPRI.

XIII. INDEX RATE

No experience data was made available as NHPRI current does not offer plans in the commercial health insurance market. As such, an index rate for the experience period was not calculated.

For the projection period, the index rate was calculated using information produced during the premium rate development process. The index rate provided reflects the estimated total allowed claims divided by total projected member months. The estimate produced reflects the utilization level, demographics, etc. of NHPRI's assumed enrollment. There will be no non-essential health benefits included in NHPRI plans. Because of this, the index rate provided aligns with the projected allowed claims PMPM.

In order to arrive at each plan's rate level based on the projected index rate, adjustments for the following items are considered:

- Cost sharing structure of the plan,
- Assumed cost sharing utilization of the plan, and
- Administrative costs.

All plans offered have a consistent provider network, utilization management, and delivery system. Additionally, items such as risk adjustment and reinsurance are accounted for consistently on all plans. Also, as previously noted non-essential health benefits will not be offered. Assumptions for cost structure and utilization differences by plan are outlined within Section XV, AV Pricing Values.

XIV. AV METAL VALUES

In the Individual market, NHPRI intends to offer two plans along with their corresponding CSR and Indian Cost-Sharing permutations.

Specifically, plans to be offered include the following:

- One plan at the Gold metal level,
- One plan at the Silver metal level,
- Three CSR plans to correspond with the Silver offering,
- One Zero Cost-Sharing plan for Indian's under 300% of FPL, and
- Two Limited Cost-Sharing plans for Indians to correspond with the Gold and Silver plans.

The AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template were based on the Federal AV Calculator. No adjustments to plan cost sharing were needed in order to determine AV using the Federal AV Calculator. While the Federal AV Calculator does not contain an input for every potential variation in plan designs, it is assumed that the majority of variation between AVs is being captured by the plan characteristics available within the Federal AV Calculator. This assumption is consistent with documentation provided within the Actuarial Value Calculator Methodology document made available by the Department of Health and Human Services.

XV. AV PRICING VALUES

AV pricing values were developed based on the allowable rating factors for each cohort in Rhode Island. In order to be consistent with the OHIC rate review process, the premium of a plan covering 100% of allowed costs for a 21-year old assuming Silver Metal Level utilization was calculated as the fixed reference plan for basis of the AV Pricing Values. We developed NHPRI's rating factors to meet the regulatory requirements below:

- Age factors as specified by law, and
- Plan factors based on the plan's actuarial value, cost sharing utilization, network, and cost of administration.

There are no assumed network differences between the plans being offered by NHPRI. Also, administrative costs are assumed to be consistent for each offering. However, certain administrative costs are developed on a PMPM basis and thus when demonstrated as a percent of premium they may vary.

The MCRM model calibrated for the purpose of developing NHPRI's manual rates was utilized for developing NHPRI's AV Pricing Values. This MCRM model is based on data from the ***Milliman Health Cost Guidelines™*** (HCGs). The HCGs provide a flexible but consistent basis for the determination of claim costs for a wide variety of health benefit plans. These rating structures are used to anticipate future claim levels, evaluate past experience and establish interrelationships between different benefit levels.

The HCGs are developed as a result of Milliman's continuing research on health care costs. They were first developed in 1954 and have been updated and expanded annually since then. These guidelines are continually monitored as we use them in measuring the experience or evaluating the rates of our clients and as we compare them to other data sources.

The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research and judgment. An extensive amount of data is used in developing these guidelines, including published and unpublished data. In most instances, cost assumptions are based upon our evaluation of several data sources and, hence, are not specifically attributable to a single source. Since these guidelines are a proprietary document of Milliman, they are only available for release to specific clients that lease these guidelines and to Milliman consulting health actuaries.

We used the calibrated MCRM model to estimate the value of cost-sharing and relative utilization of services for each plan. Our pricing models assume the same demographic and risk characteristics for each plan priced, thereby excluding expected differences in the morbidity of members assumed to select the plan.

The table below includes AV Pricing Values for the two plans offered on the Individual market. Factors are shown separately for utilization and relative AV, the product of which produces the proposed AV Pricing Value.

Table 3: Cost Sharing Utilization Factor by Metal Level

Metal Level	Cost Sharing Utilization Factor	Relative AV Factor	AV Pricing Value
Gold	1.06	0.82	0.87
Silver	1.00	0.75	0.75

For individuals enrolled in the 87% or 94% CSR plans, it was assumed that utilization will be 12% higher consistent with CMS guidance. It is assumed that NHPRI's membership will predominantly consist of CSR eligible individuals. The impact associated with CSR utilization is being applied evenly across all plan designs and metal level offerings.

XVI. MEMBERSHIP PROJECTIONS

The membership projections were developed in conjunction with NHPRI. These projections reflect market share estimates assumed by NHPRI. Additionally, the projections reflect the total market size estimated in Step 1 of the premium development process.

The population projection modeling completed in the premium rate development process was used to determine the proportion of NHPRI membership that would be eligible for CSR plans. Membership by plan and subsidy level is outlined in the table below.

Table 4: Membership by Plan and Subsidy Level

Plan	Membership
Gold	0
Silver (94% CSR)	740
Silver (87% CSR)	3,150
Silver (73% CSR)	1,819
Silver (70%)	0
Total	**5,709**

XVII. TERMINATED PRODUCTS

Not applicable. No plans are being terminated as NHPRI currently does not offer products in the Individual market.

XVIII. PLAN TYPE

Not applicable. The plan types listed in Worksheet 2, Section I of the Part I Unified Rate Review Template appropriately describe NHPRI's plans.

XIX. WARNING ALERTS

The following differences between the plan-level projections in Worksheet 2 and the total projected amounts found in Worksheet 1 were noted.

Explanations regarding these differences are as follows:

- A warning is listed in cell A82 of Worksheet 2, Plan Product Info. This warning is the result of rounding differences between values listed within the workbook. Total Premium is appropriately aligning to the nearest dollar.
- A warning is listed in cell A99 of Worksheet 2, Plan Product Info. This warning appears to be due to the template checking total allowed claims before reinsurance and risk adjustment to a calculation that represents total allowed claims after these items.

XX. EFFECTIVE RATE REVIEW INFORMATION

The following section contains additional information and documentation pertaining to the 2013 Rate Review Process OHIC Template.

As previously indicated, experience data was not available for the purpose of developing premium rates for NHPRI's products. Because of this, some sections of the OHIC Template have been intentionally left blank. Additionally, methodologies utilized for rate development purposes are consistent with those described in prior sections of the document. This section is intended to capture documentation for information not included within the Part I Unified Rate Review Template.

A. Experience Data

- **Part 1. Historical Information**
  Since no experience data was available, Part 1 has not been completed.
- **Part 2. Prospective Information**
  Since no experience data was available, sections A and C have not been completed. Section B was completed using assumptions consistent with the premium rate development process outlined in Section VII of this memorandum. The Expected Pure Medical Cost Ratio was calculated as estimated total claims PMPM divided by projected total premium PMPM. This calculation is not intended to be consistent with the Federally prescribed MLR methodology. Administrative cost percentages are consistent with values shown in Section XI of this memorandum, yet are allocated to the prescribed categories.

B. Data Collection

Information contained in this section and corresponding documentation is consistent with values shown within the Part I Unified Rate Review Template; however, it contains two additional items.

- **Base EHB Rate for Projection Period**

This value was calculated by adjusting the Index Rate to reflect the premium of a plan covering 100% of allowed cost for a 21-year old enrollee assuming Silver Metal Level utilization. To accomplish this, composite age and cost sharing utilization factors were calculated.

A description of the methodology used to calculate cost sharing utilization factors is available within Section XV of this memorandum. Additional supporting calculations have been provided within the 2013 Rate Review OHIC Template.

- **Monthly Effective Date Projection Factor**

This section is not applicable for the Individual market.

Additionally, the information requested in rows 47 and 48 of this tab is not identical to the corresponding section of the Part 1 Unified Rate Review Template. The primary difference is that the Federal template requests 'Taxes & Fees' while the 2013 OHIC Template specifically requests 'Premium Tax'. To account for this variation, Taxes and Fees other than Premium Tax have been included in the 'Administrative Expense Load' field.

C. Plan Rates

All products are new for 2014; therefore, 2013 values have been left blank within this template. Metallic Tier Actuarial Value was calculated in an identical manner as outlined in Section XIV, AV Metal Values. AVs provided within this section align with values shown in Worksheet 2 of the Part I Unified Rate Review Template. Additionally, the Proposed Plan Relativity Factors are consistent with the values outlined in Section XV, AV Pricing Values. A description and supporting information for these values can be found within that portion of this memorandum.

Membership for 1/1/2014 was estimated using membership projections as outlined in XVI, Membership Projections. As outlined within the premium development process, publically available survey data was used for the purpose of understanding the current population. Projections were performed at the member level as data was not made available at the group and/or subscriber level in the available survey data. For this reason, columns R and S have not been completed.

The proposed base rate PMPM reflects the premium of a plan covering 100% of allowed claims for a 21-year old enrollee with utilization set at the Silver Metal Level. This figure aligns with the base EHB rate shown in the second tab of the template. Pediatric Dental benefits will not be offered. Each member's rate can be calculated as the product of the EHB Base Rate, the AV Pricing Value, and the appropriate Age Factor. Please note that AV Pricing Values were developed in a different manner, yet presented as a percentage of the EHB Base Rate for filing purposes.

D. Administrative Costs

As outlined in Section XI of this memorandum, administrative costs were developed through the use of assumptions provided to Milliman from NHPRI. Prior year administrative cost data is not available due to NHPRI currently not offering products in the commercial market. Administrative costs were broken down in to the applicable categories through the use of assumptions provided to Milliman from NHPRI.

It is currently understood that there will be no Exchange Operation Fees in Rhode Island for calendar year 2014. Additionally, it is assumed that NHPRI will not be assessed the Health Insurer Tax provided that over 80% of premiums are received for Medicaid.

Additional details related to administrative costs can be found in Section XI, Non-Benefit Expenses and Profit & Risk.

XXI. RELIANCE

In developing the premium rates in this actuarial memorandum, I relied on data and other information provided by NHPRI. I have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of the analysis may likewise be inaccurate or incomplete. I performed a limited review of the data used directly in the analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of my assignment.

XXII. ACTUARIAL CERTIFICATION

I, Jeremy D. Palmer, am a member of the American Academy of Actuaries and meet its qualification standards for actuaries issuing statements of actuarial opinion in the United States. I have been retained by Neighborhood Health Plan of Rhode Island (the "Company") to prepare this filing.

I am affiliated with Milliman, Inc. ("Milliman"), an independent actuarial consulting firm that is not affiliated with, nor a subsidiary, nor in any way owned or controlled by a health plan, health insurer, or a trade association of health plans or insurers.

I hereby certify that the projected index rate is, to the best of my knowledge and understanding:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)).
- Developed in compliance with the applicable Actuarial Standards of Practice.
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Neither excessive nor deficient.

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates. The allowable modifiers used to generate plan-level rates were:

- The actuarial value and cost-sharing design of the plan.
- The plan's provider network, delivery system characteristics, and utilization management practices.
- Administrative costs, excluding Exchange user fees.

I certify that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with relevant actuarial standards of practice.

I certify that the benefits included within Neighborhood's plans are substantially equivalent to the Essential Health Benefits (EHBs) in the State of Rhode Island's benchmark plans. I certify that any benefit substitutions are:

- Actuarially equivalent to the benefits being replaced,
- Are made within only the same essential health benefit category,
- Are based on a standardized plan population,
- Are determined regardless of cost-sharing,

- Are not prescription drug benefits, and
- Are based on an analysis performed in accordance with generally accepted actuarial principles and methodologies.

I certify that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans except those specified in the certification. The AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template were based on the Federal AV Calculator. No adjustments to plan cost sharing were needed in order to determine AV using the Federal AV Calculator. While the Federal AV Calculator does not contain an input for every potential variation in plan designs, it is assumed that the majority of variation between AVs is being captured by the plan characteristics available within the Federal AV Calculator. This assumption is consistent with documentation provided within the Actuarial Value Calculator Methodology document made available by the Department of Health and Human Services.

The Part I Unified Rate Review Template and the 2013 Rate Review Process OHIC Template do not demonstrate the process used by Milliman to develop the rates. Rather, it represents information required by Federal and State regulations to be provided in support of the review of rate increases, for certification of qualified health plans that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Electronic Signature

Jeremy D. Palmer, FSA, MAAA
Principal and Consulting Actuary

April 12, 2013
Date

STATE OF RHODE ISLAND NON-GROUP INSURANCE CHECKLIST – REQURIED PROVISIONS PER 27-18-3(A)

Provisions must be "in the words or the law" or at least not less favorable.

- ☑ 1. Entire Contract
- ☑ 2. Time Limit on Certain Defenses (3 years on any misstatements excluding fraudulent)
- ☑ 3. Grace Period ---- 31 days (except weekly 7 days, monthly 10 days)
- ☑ 4. Reinstatement
- ☑ 5. Notice of Claim (20 days or as soon as reasonably possible)
- ☑ 6. Claim Forms (15 day limit for company to furnish forms)
- ☑ 7. Proof of Loss (within 90 days and NLT 1 year except in absence of legal capacity)
- ☑ 8. Time of Payment of Claims
- ☑ 9. Facility of Payment ($1,000)
- ☑ 10. Physical Examinations and Autopsy (at insurer's expense)
- ☑ 11. Legal Actions (not until 60 days from submission of proof of loss and not after three (3) years)
- ☑ 12. "Medical Services" means such professional services and supplies rendered by or under the director of persons duly licensed. Under the laws of this state to practice medicine shall not be construed to include hospital services.
- ☑ PartV, Reg.XXIII Newborn Children
- ☑ PartVI, Reg, XXII Required Statement on Application
- ☑ Part VI, Sec, 7-1 Replacement Question on Application
- ☑ Part VI, Sec. 3F Pre-Existing Condition Definition
- ☑ Part VII, Sec. %-A(12) Extension of Benefits
- ☑ Part VII, Sec. 6-A(9) 10-Day Free Look
- ☑ Part VII, Sec. 6-B Outline of Coverage
- ☑ 27-39-1 Second Surgical Opinion
- ☑ 27-18-41 Mammograms & Pap Smears
- ☑ 27-38.1-1 Pediatric Preventive Care
- ☑ 27-18-30 Infertility – Comml. Blues 27-19-23, 27-20-20 HMO's 27-41-33 Woman bet. 25 and 42 cannot conceive for 1 yr
- ☑ 27-18-31 Nurse Midwives
- ☑ New Cancer Therapies – Commercials 27-18-36, HMO's 27-19-32 and 27-20-27
- ☑ Mental Illness – 27-38.2
- ☑ Prescription Drugs – off label use for Cancer-27-55-1
- ☑ Prescription Drugs (offer of Non-Restricted Network) 27-29.1-4
- ☑ Counselors in Mental Health/Therapist Comm. 27-18-35, HMO's 27-19-35, Blues 27-19-32 and 27-20-5
- ☑ Diabetes Mandate - Comm. 27-18-38, HMO's 27-41-44, Blues 27-19-35, 27-20-30
- ☑ Mastectomy Mandate – Commercials 27-18-39, HMO's 27-41-43, Blues 27-19-34, 27-20-29
- ☑ Post-Partum Hospital – Commercials 27-18-33.1, HMO's 27-41-33.1, HMO's 27-41-43, Blues 27-19-23.1, 27-20-17.1
- ☑ Prostate & Colorectal Exams – Commercials 37-18-58, HMO's 27-41-60, Blues 27-19-49, 27-20-44
- ☑ Contraceptive Drugs & Devices – Commercials 27-18-57, HMO's 27-41-59, Blues 27-19-48, 27-20-43
- ☑ Lyme Disease – Commercials 27-18-62, HMO's 27-41-65, Blues 27-19-53, 27-20-43

- ☑ Hearing Aids $400.00 per individual Hearing Aid, per ear every 3 years, Commercials 27-18-60, HMO’s 27-41-63, Blues 27-19-51, 27-20-46
- ☑ Early Intervention Services (Dependent Con. Only) Commercials 27-18-64, HMO’s 27-41-66, Blues 27-19-54, 27-20-49
- ☑ Licensed Ambulance Services (Max.$50.00 out of pocket) Comml. 27-18-69, Blues 27-19-60, 27-20-55, HMO
- ☑ Enteral Nutritional Formulas (Max. $2500.00) Comml. 27-18-70, Blues 27-19-61, 27-20-56, HMO's 27-41-74

Clear

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Health Insurance Bulletin
2010-3

All Health Insurance Policy Forms Must be Readable at the 8th Grade Level

Applies to all policies delivered, issued for delivery, or renewed in Rhode Island on or after August 31, 2010

OHIC Regulation 5 requires all individual or group health insurance policies, contracts, certificates or agreements delivered, issued for delivery, or renewed in Rhode Island on or after August 31, 2010 to be written at or below the eighth-grade reading level as measured by the Flesch-Kincaid formula.

Effective immediately, OHIC will require that the attached certification form be completed with all health insurance form filings made through the SERFF system. A copy of this bulletin and the certification form will be available through the SERFF system.

Form filings will be acceptable if accompanied by a certification form that indicates that the text of the form produces a Flesch-Kincaid score of no higher than 8.9. Filers may submit a certification form with an alternate method or formula for evaluating readability as long as the filer can demonstrate that the alternate method or formula can be used to determine a reading level at or below the eighth-grade reading level.[1]

This requirement applies to all health insurance forms required to be submitted to OHIC for approval, including, but are not limited to, certificates of coverage, subscriber agreements, endorsements and modifications to contracts, policies, benefits booklets, and summary plan descriptions.

Christopher F. Koller
Health Insurance Commissioner
May 19, 2010

[1] In *The Art of Readable Writing*, Flesch (1949, p. 149), explained that a score of 60 to 70 resulted in an estimated reading grade level of eighth to ninth grade. We will therefore accept a Flesch Reading Ease score of 65 as an alternative to an eighth grade reading level score on the Flesch-Kincaid formula.

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OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Readability Certification

This certificate of compliance must accompany all health insurance policy form filings for every individual or group health insurance policy, contract, certificate or agreement that will be delivered, issued for delivery, or renewed in Rhode Island on or after August 31, 2010.

Instructions:

If the policy form you are submitting for approval meets the minimum reading level requirement and other standards set out by Regulation 5, please complete Section A of this certification form and skip Section B. If the policy form you are submitting for approval ***does not*** meet the minimum reading level requirement and/or other standards set out by Regulation 5, please skip Section A and complete Section B of this certification form.

Section A (To be completed only if the policy form meets the minimum reading level requirement and other standards set out by Regulation 5)

Grade level formula used. (Please check one of the following.)

☐ The text of the policy form does not exceed the eighth-grade reading level as measured by the Flesch-Kincaid formula. The Flesch-Kincaid reading level of this policy form is _____. (The score must not exceed 8.9.)

☐ We have used an alternative method or formula for evaluating the readability of the policy form instead of the Flesch-Kincaid formula. We have provided documentation to demonstrate that the alternate method or formula can be used to determine a reading level at or below the eighth-grade reading level. The reading level of this policy form is _____. (Documentation supporting the alterative method must be attached.)[2]

[2] In *The Art of Readable Writing*, Flesch (1949, p. 149), explained that a score of 60 to 70 results in an estimated reading grade level of eighth to ninth grade. We will therefore accept a Flesch Reading Ease score of 65 as an alternative to an eighth grade reading level score on the Flesch-Kincaid formula without additional supporting documentation.

Certification

I hereby certify that the form(s) submitted herewith comply with the requirements of OHIC Regulation 5, including:

- ✓ The text of the form is readable at no higher than the eighth grade level (i.e., it measures no more than 8.9 on the Flesch-Kincaid formula reading or has been shown to be written at no higher than an eighth grade level using an alternate method or formula).
- ✓ The form is printed in not less than twelve point type, excluding specification pages, schedules and tables and minor instructions.
- ✓ The style, arrangement and overall appearance of the form gives no undue prominence to any portion of the text of the policy or to any endorsements or riders.
- ✓ If the form has more than 3,000 words or more than three pages regardless of the number of words, it contains a table of contents or an index of its principal sections.
- ✓ This certification has been signed by an officer of the insurer or someone else who has specific authority to sign on behalf of and bind the insurer.

On behalf of the insurer:

_____

Signature

_____

Printed or typed name

_____

Title

_____

Date

Section B (To be completed only if the policy form does not meet the minimum reading level requirement and/or other standards set out by Regulation 5)

The policy form submitted herewith does not meet the minimum reading level requirement and/or other standards set out by Regulation 5. We request approval of the policy form pursuant to Section 6 of Regulation 5.

Filed with this certification form is:

- ✓ A statement that explains why approval is sought.
- ✓ Documentation and information to supporting the request.

This certification has been signed by an officer of the insurer or someone else who has specific authority to sign on behalf of and bind the insurer.

Signature

T. Clark Phillip

Printed or typed name

Chief Financial Officer

Title

March 8, 2013

Date

Reset Form

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

☑ **INDIVIDUAL HEALTH BENEFIT PLANS** ***(Complete SECTION A only)***

☐ **SMALL / LARGE GROUP HEALTH BENEFIT PLANS** ***(Complete SECTION B only)***

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as "major medical" in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. (*If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.*)

***For all filings, include the Type of Insurance (TOI) in the first column.**

☐ Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
Neighborhood Health Plan of Rhode Island	95402	NHRI-128972321		☑ Yes ☐ No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
H16I	**Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19**	*[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: pp. 86, Ch.6, §1.1; pp. 93, Ch.6, §1.6			
	Eliminate Annual Dollar Limits on Essential Benefits Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Low Vision p. 50, Ch.4, §2.1; Prosthetic Devices p. 60, Ch.4, §2.1; Early Intervention Services p. 41, Ch.4, §2.1			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Infertility p. 42, Ch.4, §2.1; Low Vision p. 50, Ch.4, §2.1			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain
	Explanation:			
	Page Number: pp. 115-116, Ch. 8, §3.5			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: pp viii-xiv - Summary of Benefits; p. 44-46, Ch. 4, §2.1			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: pp. 3-6, Ch. 1, §2.1; p. 8 Ch. 1, §2.3			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: pp. 18 & 20, Ch. 3, §1.3; pp. 98-109, Ch. 7, §§1-6			
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number: pp.26-28 , Ch. 3, §3.1; p. 81, Ch. 5, §1.1			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: pp. 20-22, Ch. 3, §2.1			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: pp. 22-23, Ch. 3, §2.2			

Reset Form

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 of the PHSA/Section 1201 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes**◊ ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

◊ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

Checklist for Individual and Small Group Health Insurance Plans - Policy Form
Inside and Outside the Rhode Island Health Benefit Exchange
Effective for plan years beginning on and after 1-1-2014

Company Name Neighborhood Health Plan of Rhode Island

Product Name: Neighborhood Health Plan Exchange Product 2014 – Individual Market

Plan Name: XXXX

Issuer is:
☐ certified by the Health Benefits Exchange as a QHP issuer
X licensed by OHIC to do health insurance business in RI

SERFF tracking number: NHRI-128972321
TOI Code and Sub Code: H16I – Individual Health – Major Medical
H16G.005C Individual Other

☐60% AV (Bronze)
X 70% AV (Silver)

X 80% (Gold)
☐ 90% (Platinum)
☐ Child-only
☐ Catastrophic Plan - 42 U.S.C. § 18022(e)

Filed for issuance: Inside the Exchange X Outside the Exchange ☐ Inside and Outside the Exchange ☐
Individual Market X Small Group Market☐SHOP ☐ ☐

Instructions for Checklist:

A. The Checklist for Individual and Small Group Health Insurance Plans ("Checklist") must be completed for all major medical health insurance plan policy forms offered by a health insurance issuer ("Issuer") in the individual market and in the small group market, including individual Qualified Health Plans ("QHP's") and SHOP QHP's offered on the Rhode Island Health Benefit Exchange ("Exchange").
B. The Checklist does not apply to large group health insurance plans, dental plans, or Medicare Supplemental insurance plans.
C. The terms of applicable laws and regulations shall supersede this Checklist in the case of a conflict. The omission of any requirement of the law or of a regulation from this Checklist in no way limits the authority of the Office of the Health Insurance Commissioner to enforce any other such requirement.
D. A filer shall not change or revise the Checklist.
E. By checking the "Yes" box, the Issuer certifies that the referenced provision of the health insurance plan ("Plan") complies with the associated requirement, and that the referenced provision does not contain any inconsistent, ambiguous, unfair, inequitable, or misleading clauses, or exceptions of conditions that unreasonably affect the risk purported to be assumed.

Checklist for Individual and Small Group Health Insurance Plans - Policy Form
Inside and Outside the Rhode Island Health Benefit Exchange
Effective for plan years beginning on and after 1-1-2014

F. By checking the box "N/A", the Issuer certifies that Plan does not have to comply with the associated requirement. An Explanation must be provided if this box is checked.

G. This Checklist is established by the Commissioner of the Office of the Health Insurance Commissioner ("OHIC") pursuant to OHIC Regulation 17 - "Filing and Review of Health Insurance Plan Forms and Rates." The Checklist is intended to communicate the Commissioner's considered opinion concerning what a Plan form must contain in order to satisfy the statutory and regulatory standards for approval of the form. See R.I. Gen. Laws §§ 27-18-8, 27-19-6, 27-20-6, and 27-41-29.2.

H. The Commissioner may revise the Checklist from time to time. The Checklist, and any revisions to the Checklist, will be posted on SERFF as Filing Instructions for Rhode Island.

I. The filing shall include an actuarial memorandum demonstrating the calculation and analysis used to determine: (a) the Plan's actuarial value rating, and if applicable, (b) the Plan's Catastrophic Plan status, (c) the actuarial equivalence of Essential Health Benefit substitutions, and (d) the conversion of annual or lifetime dollar limits for Essential Health Benefits to a permitted limitation.

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
General Requirements				
1. The filing must contain the entire health insurance plan policy form. • If the filer requests approval of any section, paragraph or other text in the Plan based on prior approval of the text by OHIC, the filer must identify the previously approved filing, and the page, section and paragraph where the text appears in the previously approved filing.	RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2. OHIC Regulation 17		X ☐	☐ X
Explanation: We will not provide an redline version based on OHICs request; CoC is being revised; June 1st completion date formally requested on April 11; periodic updates and reviews will be provided to OHIC				
· 2. If changes to a previously approved form are filed, the filing shall include a red-lined version of the previously approved form, and a clean version of the form as proposed to be amended.	RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2. OHIC Regulation 17		☐	X
Explanation: We will not provide an redline version based on OHICs request; CoC is being revised; June 1st completion date formally requested on April 11; periodic updates and reviews will be provided to OHIC				
3. All forms must be filed in a word-searchable format.	RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2 OHIC Regulation 17		X	☐

Checklist for Individual and Small Group Health Insurance Plans - Policy Form
Inside and Outside the Rhode Island Health Benefit Exchange
Effective for plan years beginning on and after 1-1-2014

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
Explanation:				
4. Readability. • Forms must comply with the requirements of OHIC Regulation 5, "Standards for the Readability of Health Insurance Forms". • The filing must include a Readability Certification in accordance with OHIC Regulation 5.	45 CFR §156.265(e) RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2 OHIC Regulation 5	See Page 119	X X	☐ ☐
Explanation:				
5. The filing must include the "Compliance Attestation - Forms", attached hereto as Exhibit A.	RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2. OHIC Regulation 17.	Attestation Forms Filed Separately in SERFF	X	☐
Explanation:				
Standard Policy Provisions 6. The Plan complies with state laws and regulations relating to: • The Form of the Plan. • Required Provisions • Individual Health Benefit Contracts • Group and Blanket Health Benefit Contracts	 R.I. Gen. Laws § 27-18-2 R.I. Gen. Laws § 27-18-3 OHIC/DBR Regulation 23, Part VII OHIC/DBR Regulation 23, Part VIII		 X X X X	 ☐ ☐ ☐ ☐
Explanation:				

Checklist for Individual and Small Group Health Insurance Plans - Policy Form
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Effective for plan years beginning on and after 1-1-2014

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
Form Content Requirements				
7. Essential Health Benefits ("EHB") a) The Plan must cover each of the 10 categories of Essential Health Benefits: o Ambulatory patient services o Emergency services o Hospitalization o Maternity and newborn care o Mental health and substance use disorder services, including behavioral health treatment o Prescription drugs o Rehabilitative and habilitative services and devices o Laboratory services o Preventive and wellness services and chronic disease o Pediatric services, including oral and vision care	42 U.S.C. § 18022 45 C.F.R. § 156.100 et seq.		X	☐
b) The provisions of this Section 7 apply to benefits and services covered under the Plan. The provisions of this Section 7 do not apply to cost sharing, and do not apply to utilization review standards and procedures.				
c) The Plan must cover each and every service covered in the EHB-Benchmark Plan. The components of the EHB-Benchmark Plan are: (1) the Blue Cross Vantage Blue Small Group plan ("the Base-Benchmark Plan"), including the prescription drug benefits covered by the Base-Benchmark Plan; (2) the pediatric dental benefits covered under the MetLife Federal Dental plan; (3) the pediatric vision benefits covered under the FEP Blue Vision plan; and (4) habilitative services as determined and required by subsection (h), below. **Note:** OHIC considers each of the benefits and services covered in the Base-Benchmark Plan to be included within one of the 10 Essential Health Benefits listed in subsection			X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
(a), above. If the filer proposes to exclude a benefit or service covered in the R.I. Benchmark Selections, because the filer considers the benefit or service to be not included within one of the 10 Essential Health Benefits listed in subsection (a), above, the filer must identify such benefit or services, and provide a written explanation for the exclusion. The components of the EHB-Benchmark Plan (other than habilitation services required by subsection (h), below, can be found at the following address on the OHIC website: http://www.ohic.ri.gov/2010%20Health_Reform.php				
d) The Plan must cover the services covered in the EHB-Benchmark Plan, including but not limited to each and every state benefit mandate covered in the Base-Benchmark Plan.			X	☐
e) Prescription drugs. ○ The filer must include the Plan's prescription drug formulary with the filing.			X	☐
○ The Plan must cover the greater of: (i) one drug in each United States Pharmacopeia ("USP") category or class, or (ii) the same number of prescription drugs covered in the Base-Benchmark Plan.			X	☐
○ The Plan may substitute a prescription drug covered under the Base-Benchmark Plan, provided that the substituted drug covered under the Plan is in the same USP category or class as the drug covered under the Base-Benchmark Plan. The Issuer shall identify any drug substitutions, and shall verify that the therapeutic category or class of the substituted drug covered under the Plan is the same as the therapeutic category or class of the drug covered under the Base-Benchmark Plan. In the case of formulary substitutions during the Plan year, the Issuer shall file on SERFF a notification (not subject to prior approval) identifying the substitution that has			X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
been made, and verifying that the USB category or class of the substituted drug covered under the Plan is the same as the USP category or class of the drug covered under the Base-Benchmark Plan. o The Plan shall describe the process for an enrollee to request and receive coverage of clinically appropriate drugs not on the Plan's formulary.		See Section 3.29, Pg 40	X	☐
f) A Plan that is offered outside the Exchange must cover the pediatric dental services covered by the EHB-Benchmark Plan (the MetLife Federal Dental plan for federal employees), for enrollees 18 years of age or younger; except that a Plan that is offered outside the Exchange is not required to cover the pediatric dental services covered by the EHB-Benchmark Plan if the Issuer determines, after reasonable inquiry, that the individual or small group policyholder is covered under a dental insurance plan that covers the pediatric dental services covered by the EHB-Benchmark Plan. If the individual or small group policyholder is already covered under a dental insurance plan that covers the pediatric dental services covered by the EHB-Benchmark Plan, the Issuer shall not offer the Plan with pediatric dental services; instead, the Issuer must offer a Plan that excludes pediatric dental coverage, with a premium discount equivalent to the per member per month cost of pediatric dental coverage. The Issuer's rate filing for the Plan shall include the proposed premium for the Plan with and without pediatric dental services.			☐ X	X ☐
g) The Plan must cover the pediatric vision services covered under EHB-Benchmark Plan (the FEP Blue Vision plan for federal employees) for enrollees 18 years of age or younger.		See Section 3.39, Page 82	X	☐
h) The Plan must cover habilitative services as approved by the Commissioner, in accordance with the following: Habilitative services covered under the Plan must be defined by scope, and		See Section 3.39, Page 84	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
must be at least as comprehensive (measured by per member per month cost) as the per member per month cost of rehabilitation services covered under the plan. Service visit limitations or other durational or quantitative limitations will be approved by the Commissioner only if the filer can demonstrate that no other qualitative, evidenced-based limitations less burdensome to the consumer (e.g. a process for developing limitations based on individual assessments of need) are feasible and appropriate. The filer must attach in the filing an Exhibit that (1) identifies the habilitative services covered by the plan, (2) includes an actuarial memorandum estimating the per member per month cost of the habilitative and rehabilitative services covered, and (3) includes in the actuarial memorandum the calculation and analysis used to develop the identified cost. No later than 90 days after the end of each calendar year, the Issuer must file with OHIC an actuarial memorandum, using the best available claims data, describing the Plan's claims and expense experience for habilitative and rehabilitative services during the preceding Plan year, and comparing such claims and expense experience with the approved rate factor.			X	☐
i) Substitutions. o A Plan may substitute a benefit or service for a benefit or service covered under the EHB-Benchmark Plan only if: (1) the Plan's substitute benefit or service is included within the same Essential Health Benefit category (see subsection (a), above) as the benefit or service covered under the EHB-Benchmark Plan; (2) the substitute benefit or service and the substituted benefit or service are actuarially equivalent; and (3) the substitution is approved by the Commissioner. o The filer must identify the substitution, and must file an actuarial memorandum demonstrating that the substitution is actuarially equivalent.			X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
j) A Plan may include a material deviation from a benefit or service for a benefit or service covered under the EHB-Benchmark Plan only if (1) the deviation is identified; (2) the Issuer files a memorandum demonstrating that the deviation is substantially equivalent to the EHB-Benchmark Plan; and (3) the deviation is approved by the Commissioner.			X	☐
Explanation: **NHPRI will not operate plans outside of the Exchange; therefore Pediatric Dental is not included**				
8. Cost-sharing. • Out of pocket limits. The Issuer must demonstrate in an Exhibit filed with the Plan that annual out of pocket cost sharing under the Plan does not exceed the limits established by federal and state laws and regulations, including any revisions to this Checklist. • Deductible limits. For small group Plans, the Issuer must demonstrate in an Exhibit filed with the Plan that annual deductibles under the Plan do not exceed the limits established by federal and state laws and regulations, including any revisions to this Checklist.	42 U.S.C. § 18022(c) 45 C.F.R. § 156.130(a)		X X	☐ ☐
Explanation:				
9. The Plan must contain no preexisting condition exclusions.	42 U.S.C. § 300gg-3 RI Gen Law §§ 27-18-71, 27-18.5-10, 27-19-68, 27-20-57, 27-41-81	See Page 37	X	☐
Explanation:				

Checklist for Individual and Small Group Health Insurance Plans - Policy Form
Inside and Outside the Rhode Island Health Benefit Exchange
Effective for plan years beginning on and after 1-1-2014

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
10. Lifetime dollar limits. • The Plan must contain no lifetime limits on the dollar value of any Essential Health Benefits, including the specific benefits and services covered under the EHB-Benchmark Plan. See Para. 7, above. • If the specific benefits and services covered under the Base-Benchmark Plan (See Para. 7, above) include dollar limits on the coverage of any such benefit or service, the Plan may propose an actuarially equivalent conversion of the dollar limit to a utilization limit, or some other quantitative or qualitative limit, subject to the Commissioner's approval. • If the Plan proposes a conversion the Issuer must file with the Plan an actuarial memorandum supporting the actuarially equivalent conversion.	PHSA §2711 45 CFR §147.126 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2		X ☐	☐ X X
Explanation: **Plan does not include any lifetime dollar or utilization limits for EHB**.				
11. Annual dollar limits. a) The Plan must contain no lifetime limits on the dollar value of any Essential Health Benefits, including the specific benefits and services covered under the EHB-Benchmark Plan. See Para. 7, above. b) If the specific benefits and services covered under the Base-Benchmark Plan (See Para. 7, above) include dollar limits on the coverage of any such benefit or service, the Plan may propose an actuarially equivalent conversion of the dollar limit to a utilization limit, or some other quantitative or qualitative limit, subject to the Commissioner's approval. **c)** If the Plan proposes a conversion the Issuer must file with the Plan an actuarial memorandum supporting the actuarially equivalent conversion.	42 U.S.C. § 300gg-11 45 CFR §147.126 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2		X X ☐	☐ ☐ X
Explanation: **Plan does not include any annual dollar or utilization limits for EHB**				

Requirement	Federal & State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
12. The Plan must state that the Issuer may not rescind the Plan except in cases of fraud or intentional misrepresentation of material fact. The Plan must also state that coverage may not be contested 2 years after issuance of the Plan for any reason. • Rescission is a cancellation of coverage that has retroactive effect. It includes a cancellation that voids benefits paid. • Coverage may not be rescinded except with 30 days prior notice to each enrolled person who would be affected.	42 U.S.C. § 300gg-12 45 CFR §147.128 RI Gen Law §§ 27-18-8, 27-18-72, 27-19-6, 27-19-62, 27-20-6, 27-20-58, 27-41-29.2 OHIC/DBR Reg. 23 Part VIII, Section 1(2)	See Section 2.4; Page 34 Being Revised	X	☐
Explanation:				
13. The Plan must cover preventive services without cost sharing requirements including deductibles, co-payments, and co-insurance. • Covered preventive services include: o Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the USPSTF; o Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (CDC); o Evidence-informed preventive care and screenings provided for in HRSA guidelines for infants, children, adolescents, and women; and o Current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention.	PHSA §2713 45 CFR §147.130 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2	See Section 3.3, Page 72	X	☐
Explanation:				
14. The Plan must provide coverage for dependents up to age 26 if the Plan offers dependent coverage. • Eligible children are defined based on their relationship with the participant.	42 U.S.A. § 300gg-14 45 CFR §147.120	See Page 4	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
• Limiting eligibility is prohibited based on: o financial dependency on primary subscriber, o residency, o student status, o employment, o eligibility for other coverage, o marital status. • Terms of the policy for dependent coverage cannot vary based on the age of a child.	RI Gen Law §§ 27-18-59, 27-19-50, 27-20-45, 27-41-61			
Explanation:				
15. The Plan must cover emergency services in accordance with the following: • No prior authorization. • No limitation to only services and care at participating providers. • Must cover at in-network cost-sharing level (patient is not penalized for emergency care at out-of-network provider). • Must pay for out-of-network emergency services the greatest of: (1) The median in-network rate; (2) the usual customary and reasonable rate (or similar rate determined using the plans or issuer's general formula for determining payments for out-of-network services); or (3) the Medicare rate.	42 U.S.C. § 300gg-19a(b) 45 CFR §147.138 RI Gen Law §§ 27-18-76, 27-19-66, 27-20-62, 27-41-79 SSA §1395dd	See Section 3.11; Page 48	X	☐
Explanation:				
16. For network plans requiring a primary care provider to be designated and requiring referrals: • The Plan must allow each enrollee to designate any participating primary care provider who is available to accept such individual. • The Plan must permit a physician specializing in pediatrics to	42 U.S.C. § 300gg-19a(a), (c), and (d) 45 CFR §147.138	See Section 1.12; Page 1.11 And Glossary (PCP Def)	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
be designated as primary care provider. • The Plan must not require a referral for services to be provided by in-network OB/GYNs. The Plan must treat the ordering of OB/GYN items or services by an OB/GYN as it had been ordered or authorized by the primary care provider.	RI Gen Law §§ 27-18-44		X X	☐ ☐
Explanation:				
17. In connection with maternity coverage, the Plan must provide coverage as follows: • Benefits may not be restricted to less than 48 hours following a vaginal delivery, and 96 hours following a cesarean section. This requirement does not apply if the provider, in consultation with the mother, decides to discharge the mother or the newborn prior to the minimum length of stay. • No prior authorization required for the minimum hospital stay. • For purposes of maternity coverage requirements, hospital length of stay begins at the time of delivery if delivery occurs in a hospital and at time of admission in connection with childbirth if delivery occurs outside the hospital. • No denial of mother/newborn eligibility, continued eligibility, to enroll or to renew coverage to avoid these requirements. • No monetary payments or rebates to encourage mothers to accept less than the minimum stay requirements. • No penalty for an attending provider who provides services in accordance with these requirements. • No incentives to an attending provider to induce the provider to provide care inconsistent with these requirements. • No restriction of benefits for any portion of a period within the minimum stay periods in a manner less favorable than the benefits provided for any preceding portion of such stay. • No requirement that the mother give birth in a hospital.	42 U.S.C. § 300gg-25 45 CFR §148.170 RI Gen Law §§ 27-18-33.1, 27-19-23.1, 27-20-17.1, 27-41-33.1, 27-41-43 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2	See Section 3.28; Page 38	X X	☐ ☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
• No requirement that the mother to stay in the hospital for a fixed period of time following the birth of her child.				
Explanation:				
18. The Plan must state that it provides, and must provide coverage for parity in mental health and substance use disorder benefits ("Parity"), 40in accordance with the following: • Coverage for the medical treatment of mental illness and substance abuse must be provided under the same terms and conditions as that coverage is provided for other illnesses and diseases. • The Plan must describe, through illustrations, FAQ's, or other consumer explanation how the Plan provides for Parity in connection with financial requirements, quantitative treatment limitations, prescription drug benefits, and non-quantitative treatment limitations.	42 U.S.C. § 300gg-26 45 CFR §146.136 RI Gen Law § 27-38.2-1	See Section 3.2; Page 40	X	☐
Explanation:				
19. The Plan must provide coverage for reconstructive surgery after mastectomy (Women's Health and Cancer Rights Act). The Plan must describe, through illustrations, FAQ's, or other consumer explanation how the Plan covers reconstructive surgery after mastectomy, including the scope of coverage, and cost-sharing consistent with other medical/surgical benefits.	PHSA §2727 RI Gen Law §§27-8-39, , 27-20-29, 27-41-43 OHIC Reg. 17	See Section 3.7; Page 80	X	☐
Explanation:				
20. The Plan must state that coverage is guaranteed renewable, and that the Issuer may non-renew or cancel coverage under the Plan only for nonpayment of premiums, fraud, market exit, movement outside of service area, or cessation of bona-fide association membership.	PHSA §2702 45 CFR §148.122	See Section 2.5; Page 35	X	☐

Checklist for Individual and Small Group Health Insurance Plans - Policy Form
Inside and Outside the Rhode Island Health Benefit Exchange
Effective for plan years beginning on and after 1-1-2014

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
	RI Gen Law § 27-18.5-4			
Explanation:				
21. The Plan must state that it does not limit coverage based on genetic information. 22. The Plan must state that the Issuer will not: (i) adjust premiums based on genetic information; (ii) request /require genetic testing; (iii) or collect genetic information from an individual prior to, or in connection with enrollment in a plan, or at any time for underwriting purposes.	PHSA §2753 45 CFR §148.180 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2	See Section 3.0; Page 38	X X	☐ ☐
Explanation:				
23. The Plan must provide coverage for individuals participating in approved clinical trials. The Plan must describe, through illustrations, FAQ's, or other consumer explanation how the Plan provides such coverage, including the scope of coverage, individuals qualified, clinical trials that will be approved, and network provider limitations.	42 U.S.C. § 300gg-8 RI Gen Law §§ 27-18-74, 27-19-64, 27-20-60, 27-41-77	See Section 3.12; Page 50	X	☐
Explanation:				
24. The Plan must state that the enrollee may terminate coverage upon no greater than 14 days notice to the Issuer or the Exchange. 25. For QHPs only, the Plan must state that the Issuer is permitted to terminate coverage if: • The enrollee is no longer eligible for coverage through the Exchange. • Payment of premiums cease (after appropriate grace periods	45 CFR § 155.430 45 CFR § 156.270(d) - (g) RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2 RI Gen Law § 27-18-3(a)(3);	See Section 2.4; Page 34 See Section 2.4; Pg 34; Being Revised	X X	☐ ☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
applied as described below); • The enrollee's coverage is rescinded for a non-prohibited reason. • The Qualified Health Plan is terminated or decertified. • The enrollee changes from one plan to another through during an open or special enrollment period.				
26. The Plan must state that if coverage is terminated, 30 days prior notice is required, and the notice must include the reason for termination.		See Section 2.4; Page 34 Being Revised	X	☐
27. The Plan must state that a 3 month grace period is provided for enrollees in a Qualified Health Plan who are recipients of advance payments of premium tax credit. The Issuer must provide the enrollee with notice of payment delinquency, unless the Exchange has accepted the obligation to do so on behalf of the Issuer.		See Section 2.4; Page 34; Being Revised	X	☐
28. For all other enrollees, the Plan must state that a 30 day grace period is provided.		See Section 2.4; Page 34; Being Revised	X	☐
Explanation:				
Claims, Internal Appeals, and External Appeals 29. The Plan must include a description of its claims procedures, procedures for obtaining prior approval, preauthorization procedures, utilization review procedures, adverse benefit determination procedures, internal appeals, external appeals, and **the** applicable time frames for these policies and procedures. Such policies and procedures must be in accordance with federal laws and regulations, in accordance with state laws and regulations that are not in conflict with such federal laws and regulations, and in accordance with the requirements of this checklist.	42 U.S.C. § 300gg-19 45 CFR § 147.136 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2 RI Gen Law §§ 23-17.12-1 et seq., 23-17-13-1 et seq. (where not in conflict with federal laws and regulations).	See Section 7; Page 101	X	☐
30. The Plan must include the standards, including the Plan's medical		See Section 7.3; Page 103	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
necessity standard, applicable to prior approval, preauthorization, and utilization review procedures. The Plan's definition of "medical necessity" must: • Require coverage of health care services that are appropriate, in terms of type, amount, frequency, level, setting, and duration to the member's diagnosis or condition. • Must be informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters.	DOH Regulations 23-17-12-UR and 23-17.13-CHP (where not in conflict with federal laws and regulations).			
31. The Plan must explain to the enrollee how to obtain the clinical review criteria used to determine medical necessity in a particular situation.		See Section 1.5; Page 27	X	☐
32. The Plan's definition of adverse benefit determination must be the definition used in 29 C.F.R. § 2560.530-1. The term also includes a rescission of coverage.		See Section 1.5; Page 27	X	☐
33. In connection with external appeals, the Plan must provide that: • The cost of an external appeal must be borne by the issuer. • The claimant must not be charged a filing fee greater than $25. • Restrictions on the minimum dollar amount of a claim are not allowed. • The decision of the Independent Review Organization is binding on the issuer.		See Section 7.3; Page 103	X	☐
Explanation:				

Checklist for Individual and Small Group Health Insurance Plans - Policy Form
Inside and Outside the Rhode Island Health Benefit Exchange
Effective for plan years beginning on and after 1-1-2014

Company Name Neighborhood Health Plan of Rhode Island

Product Name: Neighborhood Health Plan Exchange Product 2014 – Individual Market

Plan Name: XXXX

Issuer is:
☐ certified by the Health Benefits Exchange as a QHP issuer
X licensed by OHIC to do health insurance business in RI

SERFF tracking number: NHRI-128972321
TOI Code and Sub Code: H16I – Individual Health – Major Medical
H16G.005C Individual Other

☐60% AV (Bronze)
X 70% AV (Silver)

X 80% (Gold)
☐ 90% (Platinum)
☐ Child-only
☐ Catastrophic Plan - 42 U.S.C. § 18022(e)

Filed for issuance: Inside the Exchange X Outside the Exchange ☐ Inside and Outside the Exchange ☐
Individual Market X Small Group Market☐SHOP ☐ ☐

Instructions for Checklist:

A. The Checklist for Individual and Small Group Health Insurance Plans ("Checklist") must be completed for all major medical health insurance plan policy forms offered by a health insurance issuer ("Issuer") in the individual market and in the small group market, including individual Qualified Health Plans ("QHP's") and SHOP QHP's offered on the Rhode Island Health Benefit Exchange ("Exchange").
B. The Checklist does not apply to large group health insurance plans, dental plans, or Medicare Supplemental insurance plans.
C. The terms of applicable laws and regulations shall supersede this Checklist in the case of a conflict. The omission of any requirement of the law or of a regulation from this Checklist in no way limits the authority of the Office of the Health Insurance Commissioner to enforce any other such requirement.
D. A filer shall not change or revise the Checklist.
E. By checking the "Yes" box, the Issuer certifies that the referenced provision of the health insurance plan ("Plan") complies with the associated requirement, and that the referenced provision does not contain any inconsistent, ambiguous, unfair, inequitable, or misleading clauses, or exceptions of conditions that unreasonably affect the risk purported to be assumed.

Checklist for Individual and Small Group Health Insurance Plans - Policy Form
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Effective for plan years beginning on and after 1-1-2014

F. By checking the box "N/A", the Issuer certifies that Plan does not have to comply with the associated requirement. An Explanation must be provided if this box is checked.

G. This Checklist is established by the Commissioner of the Office of the Health Insurance Commissioner ("OHIC") pursuant to OHIC Regulation 17 - "Filing and Review of Health Insurance Plan Forms and Rates." The Checklist is intended to communicate the Commissioner's considered opinion concerning what a Plan form must contain in order to satisfy the statutory and regulatory standards for approval of the form. See R.I. Gen. Laws §§ 27-18-8, 27-19-6, 27-20-6, and 27-41-29.2.

H. The Commissioner may revise the Checklist from time to time. The Checklist, and any revisions to the Checklist, will be posted on SERFF as Filing Instructions for Rhode Island.

I. The filing shall include an actuarial memorandum demonstrating the calculation and analysis used to determine: (a) the Plan's actuarial value rating, and if applicable, (b) the Plan's Catastrophic Plan status, (c) the actuarial equivalence of Essential Health Benefit substitutions, and (d) the conversion of annual or lifetime dollar limits for Essential Health Benefits to a permitted limitation.

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
General Requirements				
1. The filing must contain the entire health insurance plan policy form. • If the filer requests approval of any section, paragraph or other text in the Plan based on prior approval of the text by OHIC, the filer must identify the previously approved filing, and the page, section and paragraph where the text appears in the previously approved filing.	RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2. OHIC Regulation 17		X ☐	☐ X
Explanation: We will not provide an redline version based on OHICs request; CoC is being revised; June 1st completion date formally requested on April 11; periodic updates and reviews will be provided to OHIC				
· 2. If changes to a previously approved form are filed, the filing shall include a red-lined version of the previously approved form, and a clean version of the form as proposed to be amended.	RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2. OHIC Regulation 17		☐	X
Explanation: We will not provide an redline version based on OHICs request; CoC is being revised; June 1st completion date formally requested on April 11; periodic updates and reviews will be provided to OHIC				
3. All forms must be filed in a word-searchable format.	RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2 OHIC Regulation 17		X	☐

Checklist for Individual and Small Group Health Insurance Plans - Policy Form
Inside and Outside the Rhode Island Health Benefit Exchange
Effective for plan years beginning on and after 1-1-2014

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
Explanation:				
4. Readability. • Forms must comply with the requirements of OHIC Regulation 5, "Standards for the Readability of Health Insurance Forms". • The filing must include a Readability Certification in accordance with OHIC Regulation 5.	45 CFR §156.265(e) RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2 OHIC Regulation 5	See Page 119	X X	☐ ☐
Explanation:				
5. The filing must include the "Compliance Attestation - Forms", attached hereto as Exhibit A.	RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2. OHIC Regulation 17.	Attestation Forms Filed Separately in SERFF	X	☐
Explanation:				
Standard Policy Provisions 6. The Plan complies with state laws and regulations relating to: • The Form of the Plan. • Required Provisions • Individual Health Benefit Contracts • Group and Blanket Health Benefit Contracts	 R.I. Gen. Laws § 27-18-2 R.I. Gen. Laws § 27-18-3 OHIC/DBR Regulation 23, Part VII OHIC/DBR Regulation 23, Part VIII		 X X X X	 ☐ ☐ ☐ ☐
Explanation:				

Checklist for Individual and Small Group Health Insurance Plans - Policy Form
Inside and Outside the Rhode Island Health Benefit Exchange
Effective for plan years beginning on and after 1-1-2014

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
Form Content Requirements				
7. Essential Health Benefits ("EHB") a) The Plan must cover each of the 10 categories of Essential Health Benefits: o Ambulatory patient services o Emergency services o Hospitalization o Maternity and newborn care o Mental health and substance use disorder services, including behavioral health treatment o Prescription drugs o Rehabilitative and habilitative services and devices o Laboratory services o Preventive and wellness services and chronic disease o Pediatric services, including oral and vision care	42 U.S.C. § 18022 45 C.F.R. § 156.100 et seq.		X	☐
b) The provisions of this Section 7 apply to benefits and services covered under the Plan. The provisions of this Section 7 do not apply to cost sharing, and do not apply to utilization review standards and procedures.				
c) The Plan must cover each and every service covered in the EHB-Benchmark Plan. The components of the EHB-Benchmark Plan are: (1) the Blue Cross Vantage Blue Small Group plan ("the Base-Benchmark Plan"), including the prescription drug benefits covered by the Base-Benchmark Plan; (2) the pediatric dental benefits covered under the MetLife Federal Dental plan; (3) the pediatric vision benefits covered under the FEP Blue Vision plan; and (4) habilitative services as determined and required by subsection (h), below. **Note:** OHIC considers each of the benefits and services covered in the Base-Benchmark Plan to be included within one of the 10 Essential Health Benefits listed in subsection			X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
(a), above. If the filer proposes to exclude a benefit or service covered in the R.I. Benchmark Selections, because the filer considers the benefit or service to be not included within one of the 10 Essential Health Benefits listed in subsection (a), above, the filer must identify such benefit or services, and provide a written explanation for the exclusion. The components of the EHB-Benchmark Plan (other than habilitation services required by subsection (h), below, can be found at the following address on the OHIC website: http://www.ohic.ri.gov/2010%20Health_Reform.php				
d) The Plan must cover the services covered in the EHB-Benchmark Plan, including but not limited to each and every state benefit mandate covered in the Base-Benchmark Plan.			X	☐
e) Prescription drugs. ○ The filer must include the Plan's prescription drug formulary with the filing.			X	☐
○ The Plan must cover the greater of: (i) one drug in each United States Pharmacopeia ("USP") category or class, or (ii) the same number of prescription drugs covered in the Base-Benchmark Plan.			X	☐
○ The Plan may substitute a prescription drug covered under the Base-Benchmark Plan, provided that the substituted drug covered under the Plan is in the same USP category or class as the drug covered under the Base-Benchmark Plan. The Issuer shall identify any drug substitutions, and shall verify that the therapeutic category or class of the substituted drug covered under the Plan is the same as the therapeutic category or class of the drug covered under the Base-Benchmark Plan. In the case of formulary substitutions during the Plan year, the Issuer shall file on SERFF a notification (not subject to prior approval) identifying the substitution that has			X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
been made, and verifying that the USB category or class of the substituted drug covered under the Plan is the same as the USP category or class of the drug covered under the Base-Benchmark Plan. o The Plan shall describe the process for an enrollee to request and receive coverage of clinically appropriate drugs not on the Plan's formulary.		See Section 3.29, Pg 40	X	☐
f) A Plan that is offered outside the Exchange must cover the pediatric dental services covered by the EHB-Benchmark Plan (the MetLife Federal Dental plan for federal employees), for enrollees 18 years of age or younger; except that a Plan that is offered outside the Exchange is not required to cover the pediatric dental services covered by the EHB-Benchmark Plan if the Issuer determines, after reasonable inquiry, that the individual or small group policyholder is covered under a dental insurance plan that covers the pediatric dental services covered by the EHB-Benchmark Plan. If the individual or small group policyholder is already covered under a dental insurance plan that covers the pediatric dental services covered by the EHB-Benchmark Plan, the Issuer shall not offer the Plan with pediatric dental services; instead, the Issuer must offer a Plan that excludes pediatric dental coverage, with a premium discount equivalent to the per member per month cost of pediatric dental coverage. The Issuer's rate filing for the Plan shall include the proposed premium for the Plan with and without pediatric dental services.			☐ X	X ☐
g) The Plan must cover the pediatric vision services covered under EHB-Benchmark Plan (the FEP Blue Vision plan for federal employees) for enrollees 18 years of age or younger.		See Section 3.39, Page 82	X	☐
h) The Plan must cover habilitative services as approved by the Commissioner, in accordance with the following: Habilitative services covered under the Plan must be defined by scope, and		See Section 3.39, Page 84	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
must be at least as comprehensive (measured by per member per month cost) as the per member per month cost of rehabilitation services covered under the plan. Service visit limitations or other durational or quantitative limitations will be approved by the Commissioner only if the filer can demonstrate that no other qualitative, evidenced-based limitations less burdensome to the consumer (e.g. a process for developing limitations based on individual assessments of need) are feasible and appropriate. The filer must attach in the filing an Exhibit that (1) identifies the habilitative services covered by the plan, (2) includes an actuarial memorandum estimating the per member per month cost of the habilitative and rehabilitative services covered, and (3) includes in the actuarial memorandum the calculation and analysis used to develop the identified cost. No later than 90 days after the end of each calendar year, the Issuer must file with OHIC an actuarial memorandum, using the best available claims data, describing the Plan's claims and expense experience for habilitative and rehabilitative services during the preceding Plan year, and comparing such claims and expense experience with the approved rate factor.			X	☐
i) Substitutions. o A Plan may substitute a benefit or service for a benefit or service covered under the EHB-Benchmark Plan only if: (1) the Plan's substitute benefit or service is included within the same Essential Health Benefit category (see subsection (a), above) as the benefit or service covered under the EHB-Benchmark Plan; (2) the substitute benefit or service and the substituted benefit or service are actuarially equivalent; and (3) the substitution is approved by the Commissioner. o The filer must identify the substitution, and must file an actuarial memorandum demonstrating that the substitution is actuarially equivalent.			X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
j) A Plan may include a material deviation from a benefit or service for a benefit or service covered under the EHB-Benchmark Plan only if (1) the deviation is identified; (2) the Issuer files a memorandum demonstrating that the deviation is substantially equivalent to the EHB-Benchmark Plan; and (3) the deviation is approved by the Commissioner.			X	☐
Explanation: **NHPRI will not operate plans outside of the Exchange; therefore Pediatric Dental is not included**				
8. Cost-sharing. • Out of pocket limits. The Issuer must demonstrate in an Exhibit filed with the Plan that annual out of pocket cost sharing under the Plan does not exceed the limits established by federal and state laws and regulations, including any revisions to this Checklist. • Deductible limits. For small group Plans, the Issuer must demonstrate in an Exhibit filed with the Plan that annual deductibles under the Plan do not exceed the limits established by federal and state laws and regulations, including any revisions to this Checklist.	42 U.S.C. § 18022(c) 45 C.F.R. § 156.130(a)		X X	☐ ☐
Explanation:				
9. The Plan must contain no preexisting condition exclusions.	42 U.S.C. § 300gg-3 RI Gen Law §§ 27-18-71, 27-18.5-10, 27-19-68, 27-20-57, 27-41-81	See Page 37	X	☐
Explanation:				

Checklist for Individual and Small Group Health Insurance Plans - Policy Form
Inside and Outside the Rhode Island Health Benefit Exchange
Effective for plan years beginning on and after 1-1-2014

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
10. Lifetime dollar limits. • The Plan must contain no lifetime limits on the dollar value of any Essential Health Benefits, including the specific benefits and services covered under the EHB-Benchmark Plan. See Para. 7, above. • If the specific benefits and services covered under the Base-Benchmark Plan (See Para. 7, above) include dollar limits on the coverage of any such benefit or service, the Plan may propose an actuarially equivalent conversion of the dollar limit to a utilization limit, or some other quantitative or qualitative limit, subject to the Commissioner's approval. • If the Plan proposes a conversion the Issuer must file with the Plan an actuarial memorandum supporting the actuarially equivalent conversion.	PHSA §2711 45 CFR §147.126 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2		X ☐	☐ X X
Explanation: **Plan does not include any lifetime dollar or utilization limits for EHB**.				
11. Annual dollar limits. a) The Plan must contain no lifetime limits on the dollar value of any Essential Health Benefits, including the specific benefits and services covered under the EHB-Benchmark Plan. See Para. 7, above. b) If the specific benefits and services covered under the Base-Benchmark Plan (See Para. 7, above) include dollar limits on the coverage of any such benefit or service, the Plan may propose an actuarially equivalent conversion of the dollar limit to a utilization limit, or some other quantitative or qualitative limit, subject to the Commissioner's approval. **c)** If the Plan proposes a conversion the Issuer must file with the Plan an actuarial memorandum supporting the actuarially equivalent conversion.	42 U.S.C. § 300gg-11 45 CFR §147.126 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2		X X ☐	☐ ☐ X
Explanation: **Plan does not include any annual dollar or utilization limits for EHB**				

Requirement	Federal & State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
12. The Plan must state that the Issuer may not rescind the Plan except in cases of fraud or intentional misrepresentation of material fact. The Plan must also state that coverage may not be contested 2 years after issuance of the Plan for any reason. • Rescission is a cancellation of coverage that has retroactive effect. It includes a cancellation that voids benefits paid. • Coverage may not be rescinded except with 30 days prior notice to each enrolled person who would be affected.	42 U.S.C. § 300gg-12 45 CFR §147.128 RI Gen Law §§ 27-18-8, 27-18-72, 27-19-6, 27-19-62, 27-20-6, 27-20-58, 27-41-29.2 OHIC/DBR Reg. 23 Part VIII, Section 1(2)	See Section 2.4; Page 34 Being Revised	X	☐
Explanation:				
13. The Plan must cover preventive services without cost sharing requirements including deductibles, co-payments, and co-insurance. • Covered preventive services include: o Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the USPSTF; o Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (CDC); o Evidence-informed preventive care and screenings provided for in HRSA guidelines for infants, children, adolescents, and women; and o Current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention.	PHSA §2713 45 CFR §147.130 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2	See Section 3.3, Page 72	X	☐
Explanation:				
14. The Plan must provide coverage for dependents up to age 26 if the Plan offers dependent coverage. • Eligible children are defined based on their relationship with the participant.	42 U.S.A. § 300gg-14 45 CFR §147.120	See Page 4	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
• Limiting eligibility is prohibited based on: o financial dependency on primary subscriber, o residency, o student status, o employment, o eligibility for other coverage, o marital status. • Terms of the policy for dependent coverage cannot vary based on the age of a child.	RI Gen Law §§ 27-18-59, 27-19-50, 27-20-45, 27-41-61			
Explanation:				
15. The Plan must cover emergency services in accordance with the following: • No prior authorization. • No limitation to only services and care at participating providers. • Must cover at in-network cost-sharing level (patient is not penalized for emergency care at out-of-network provider). • Must pay for out-of-network emergency services the greatest of: (1) The median in-network rate; (2) the usual customary and reasonable rate (or similar rate determined using the plans or issuer's general formula for determining payments for out-of-network services); or (3) the Medicare rate.	42 U.S.C. § 300gg-19a(b) 45 CFR §147.138 RI Gen Law §§ 27-18-76, 27-19-66, 27-20-62, 27-41-79 SSA §1395dd	See Section 3.11; Page 48	X	☐
Explanation:				
16. For network plans requiring a primary care provider to be designated and requiring referrals: • The Plan must allow each enrollee to designate any participating primary care provider who is available to accept such individual. • The Plan must permit a physician specializing in pediatrics to	42 U.S.C. § 300gg-19a(a), (c), and (d) 45 CFR §147.138	See Section 1.12; Page 1.11 And Glossary (PCP Def)	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
be designated as primary care provider. • The Plan must not require a referral for services to be provided by in-network OB/GYNs. The Plan must treat the ordering of OB/GYN items or services by an OB/GYN as it had been ordered or authorized by the primary care provider.	RI Gen Law §§ 27-18-44		X X	☐ ☐
Explanation:				
17. In connection with maternity coverage, the Plan must provide coverage as follows: • Benefits may not be restricted to less than 48 hours following a vaginal delivery, and 96 hours following a cesarean section. This requirement does not apply if the provider, in consultation with the mother, decides to discharge the mother or the newborn prior to the minimum length of stay. • No prior authorization required for the minimum hospital stay. • For purposes of maternity coverage requirements, hospital length of stay begins at the time of delivery if delivery occurs in a hospital and at time of admission in connection with childbirth if delivery occurs outside the hospital. • No denial of mother/newborn eligibility, continued eligibility, to enroll or to renew coverage to avoid these requirements. • No monetary payments or rebates to encourage mothers to accept less than the minimum stay requirements. • No penalty for an attending provider who provides services in accordance with these requirements. • No incentives to an attending provider to induce the provider to provide care inconsistent with these requirements. • No restriction of benefits for any portion of a period within the minimum stay periods in a manner less favorable than the benefits provided for any preceding portion of such stay. • No requirement that the mother give birth in a hospital.	42 U.S.C. § 300gg-25 45 CFR §148.170 RI Gen Law §§ 27-18-33.1, 27-19-23.1, 27-20-17.1, 27-41-33.1, 27-41-43 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2	See Section 3.28; Page 38	X X	☐ ☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
• No requirement that the mother to stay in the hospital for a fixed period of time following the birth of her child.				
Explanation:				
18. The Plan must state that it provides, and must provide coverage for parity in mental health and substance use disorder benefits ("Parity"), 40in accordance with the following: • Coverage for the medical treatment of mental illness and substance abuse must be provided under the same terms and conditions as that coverage is provided for other illnesses and diseases. • The Plan must describe, through illustrations, FAQ's, or other consumer explanation how the Plan provides for Parity in connection with financial requirements, quantitative treatment limitations, prescription drug benefits, and non-quantitative treatment limitations.	42 U.S.C. § 300gg-26 45 CFR §146.136 RI Gen Law § 27-38.2-1	See Section 3.2; Page 40	X	☐
Explanation:				
19. The Plan must provide coverage for reconstructive surgery after mastectomy (Women's Health and Cancer Rights Act). The Plan must describe, through illustrations, FAQ's, or other consumer explanation how the Plan covers reconstructive surgery after mastectomy, including the scope of coverage, and cost-sharing consistent with other medical/surgical benefits.	PHSA §2727 RI Gen Law §§27-8-39, , 27-20-29, 27-41-43 OHIC Reg. 17	See Section 3.7; Page 80	X	☐
Explanation:				
20. The Plan must state that coverage is guaranteed renewable, and that the Issuer may non-renew or cancel coverage under the Plan only for nonpayment of premiums, fraud, market exit, movement outside of service area, or cessation of bona-fide association membership.	PHSA §2702 45 CFR §148.122	See Section 2.5; Page 35	X	☐

Checklist for Individual and Small Group Health Insurance Plans - Policy Form
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Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
	RI Gen Law § 27-18.5-4			
Explanation:				
21. The Plan must state that it does not limit coverage based on genetic information. 22. The Plan must state that the Issuer will not: (i) adjust premiums based on genetic information; (ii) request /require genetic testing; (iii) or collect genetic information from an individual prior to, or in connection with enrollment in a plan, or at any time for underwriting purposes.	PHSA §2753 45 CFR §148.180 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2	See Section 3.0; Page 38	X X	☐ ☐
Explanation:				
23. The Plan must provide coverage for individuals participating in approved clinical trials. The Plan must describe, through illustrations, FAQ's, or other consumer explanation how the Plan provides such coverage, including the scope of coverage, individuals qualified, clinical trials that will be approved, and network provider limitations.	42 U.S.C. § 300gg-8 RI Gen Law §§ 27-18-74, 27-19-64, 27-20-60, 27-41-77	See Section 3.12; Page 50	X	☐
Explanation:				
24. The Plan must state that the enrollee may terminate coverage upon no greater than 14 days notice to the Issuer or the Exchange. 25. For QHPs only, the Plan must state that the Issuer is permitted to terminate coverage if: • The enrollee is no longer eligible for coverage through the Exchange. • Payment of premiums cease (after appropriate grace periods	45 CFR § 155.430 45 CFR § 156.270(d) - (g) RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2 RI Gen Law § 27-18-3(a)(3);	See Section 2.4; Page 34 See Section 2.4; Pg 34; Being Revised	X X	☐ ☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
applied as described below); • The enrollee's coverage is rescinded for a non-prohibited reason. • The Qualified Health Plan is terminated or decertified. • The enrollee changes from one plan to another through during an open or special enrollment period.				
26. The Plan must state that if coverage is terminated, 30 days prior notice is required, and the notice must include the reason for termination.		See Section 2.4; Page 34 Being Revised	X	☐
27. The Plan must state that a 3 month grace period is provided for enrollees in a Qualified Health Plan who are recipients of advance payments of premium tax credit. The Issuer must provide the enrollee with notice of payment delinquency, unless the Exchange has accepted the obligation to do so on behalf of the Issuer.		See Section 2.4; Page 34; Being Revised	X	☐
28. For all other enrollees, the Plan must state that a 30 day grace period is provided.		See Section 2.4; Page 34; Being Revised	X	☐
Explanation:				
Claims, Internal Appeals, and External Appeals 29. The Plan must include a description of its claims procedures, procedures for obtaining prior approval, preauthorization procedures, utilization review procedures, adverse benefit determination procedures, internal appeals, external appeals, and **the** applicable time frames for these policies and procedures. Such policies and procedures must be in accordance with federal laws and regulations, in accordance with state laws and regulations that are not in conflict with such federal laws and regulations, and in accordance with the requirements of this checklist.	42 U.S.C. § 300gg-19 45 CFR § 147.136 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2 RI Gen Law §§ 23-17.12-1 et seq., 23-17-13-1 et seq. (where not in conflict with federal laws and regulations).	See Section 7; Page 101	X	☐
30. The Plan must include the standards, including the Plan's medical		See Section 7.3; Page 103	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
necessity standard, applicable to prior approval, preauthorization, and utilization review procedures. The Plan's definition of "medical necessity" must: • Require coverage of health care services that are appropriate, in terms of type, amount, frequency, level, setting, and duration to the member's diagnosis or condition. • Must be informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters.	DOH Regulations 23-17-12-UR and 23-17.13-CHP (where not in conflict with federal laws and regulations).			
31. The Plan must explain to the enrollee how to obtain the clinical review criteria used to determine medical necessity in a particular situation.		See Section 1.5; Page 27	X	☐
32. The Plan's definition of adverse benefit determination must be the definition used in 29 C.F.R. § 2560.530-1. The term also includes a rescission of coverage.		See Section 1.5; Page 27	X	☐
33. In connection with external appeals, the Plan must provide that: • The cost of an external appeal must be borne by the issuer. • The claimant must not be charged a filing fee greater than $25. • Restrictions on the minimum dollar amount of a claim are not allowed. • The decision of the Independent Review Organization is binding on the issuer.		See Section 7.3; Page 103	X	☐
Explanation:				

RHODE ISLAND ACTUARIAL CERTIFICATION

Carrier: Neighborhood Health Plan Of Rhode Island

Submission:

Neighborhood - Individual Market Product

I hereby certify that to the best of my knowledge and belief, the above submission conforms to generally accepted actuarial principles, standards and guidelines, that the reserves, including a test of deficiency reserves, and non-forfeiture benefits, if applicable, comply with all statutes, rules and regulations of the state of Rhode Island, and that premiums, if any, are not inadequate, excessive, unfairly discriminatory, or unreasonable in relation to benefits.

Signature of qualified actuary: Jeremy D. Palmer Electronic Signature

Name (typed or printed): Jeremy D. Palmer, FSA, MAAA

Title or business affiliation: Principal & Consulting Actuary, Milliman Inc.

Date: 4/12/2013

A thorough review of the law, bulletins, and the Rating Compliance Guidelines should be made prior to signing this certification.

Reset Form

Milliman

NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND

Individual Market Products
Actuarial Memorandum

I. SCOPE AND PURPOSE

Milliman, Inc. (Milliman) has been retained by Neighborhood Health Plan of Rhode Island (NHPRI) to prepare the premium rates and actuarial memorandum for Individual market products to be offered on the Rhode Island Health Benefit Exchange (RIHBE).

This document contains the Part III Actuarial Memorandum for NHPRI's Individual block of business, effective January 1, 2014. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template. This actuarial memorandum will also serve as the memorandum to support the 2013 Rate Review Process OHIC Template. The memorandum is intended to demonstrate that the premiums for these products are reasonable in relation to the benefits provided and to demonstrate compliance with regulatory authority. This memorandum may not be appropriate for any other purpose.

This actuarial memorandum has been prepared to be included in NHPRI's rate filings and is intended for use by the State of Rhode Island Office of the Health Insurance Commissioner (OHIC), the Rhode Island Health Benefit Exchange (RIHBE), the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of NHPRI's filings. However, we recognize that this certification may become a public document. Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this actuarial memorandum prepared for NHPRI by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

The memorandum does not guarantee that the rates will be adequate. Rather, the filing shows that the rates will be adequate if the assumptions underlying their development are realized.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

II. GENERAL INFORMATION

General Information related to NHPRI and the policies applicable to this actuarial memorandum are made available below.

A. Company Identifying Information

- Company Legal Name: Neighborhood Health Plan of Rhode Island
- State: The State of Rhode Island has regulatory authority over these policies
- HIOS Issuer ID: 77514
- Market: Individual
- Effective Date: January 1, 2014

B. Company Contact Information

- Primary Contact Name: Mr. T. Clark Phillip, CPA, Chief Financial Officer
- Primary Contact Telephone Number: (401) 459-6611
- Primary Contact Email Address: cphillip@nhpri.org

III. PROPOSED RATE INCREASE

Not applicable. The proposed rates within this actuarial memorandum are for new products that are intended to be offered on the RIHBE. NHPRI currently does not offer any products in the commercial health insurance market. As such, there are no rate adjustments being proposed.

IV. EXPERIENCE PERIOD PREMIUM AND CLAIMS

Not applicable. NHPRI currently does not offer any products in the commercial health insurance market. Because of this, no relevant experience based premium and/or claims data is available. The premium rates and corresponding factors proposed in this memorandum are based on a manual rate development process.

V. BENEFIT CATEGORIES

Not applicable. As no relevant data was available for the purpose of developing premium rates, experience data was not summarized by benefit category. The premium rates and corresponding factors proposed in this memorandum are based on a manual rate development process.

VI. PROJECTION FACTORS

Not applicable. Factors were not developed for the purpose of projecting experience period allowed claims, since no experience data was available. The premium rates and corresponding factors proposed in this memorandum are based on a manual rate development process. Assumptions for items such as morbidity changes, demographic changes, and trend were considered in developing manual rates as described in Section VII.

VII. CREDIBILITY MANUAL RATE DEVELOPMENT

NHPRI currently does not offer any products in the commercial health insurance market, which results in no experience data being available. For this reason, the premium rates and corresponding factors proposed in this memorandum are solely based on the manual rate development process.

In order to estimate premium rates for NHPRI products, the following steps were performed. These steps outline the premium development process including Population Assumptions (including morbidity and pent-up demand), Claim Costs, Administrative Expenses, Risk Adjustment Transfer, and Federal Transitional Reinsurance. While some of these items may fall outside of the scope of manual rate development, it is important to understand the process in its entirety.

A. Step 1: Project Statewide Market Members and Health Status by Population Cohort

We anticipate shifts in the insured population when the Rhode Island Health Benefit Exchange opens in 2014. We projected Rhode Island statewide members and their health status to help determine NHPRI's share of the market, the morbidity of their members, and NHPRI's risk adjustment receipts or payments.

For the purpose of projecting Rhode Island membership, a population projection model developed by Milliman's Indianapolis Health Practice was utilized (the Model). This model estimates the calendar year 2011 insurance market population and applies assumptions in order to project the developed population to future years. Estimated insurance market population counts are divided into cohorts that represent a combination of age, gender, household income (measured as percent of the Federal Poverty Level), and self-reported health status. Insurance coverage's incorporated in the model include Medicaid, Medicare, Individual Insured, Small Group Insured, Large Group Insured, Self-Funded, Employer Part-Time, Employer Retiree, and Uninsured. For each type of insurance coverage, enrollment is estimated by percent of Federal Poverty Level, Age, and Gender. Additionally, morbidity assumptions for both the baseline period and projection period are estimated.

The model uses the latest data available from multiple public and proprietary sources in order to understand the current market population by insurance coverage, age, gender, percent of Federal Poverty Level (FPL), health status, and Metropolitan Statistical Area (MSA).

The data utilized by the Model is comprised of public data sources outlined below.

- Current Population Survey (CPS) data – This data, which is updated monthly, provides us with demographic information by insurance coverage, age, FPL, and health status. In order to obtain a credible sample size, CPS data from 2009 through 2011 is summarized. In situations where CPS sample size credibility is a concern, state data is blended with the corresponding HHS regional data to further enhance credibility in modeling results.
- American Community Survey (ACS) data – Because of a larger sample size, ACS data is used in order to provide more accurate enrollment counts by insurance coverage, age, gender, and FPL. This population count data is merged with the CPS data by health status in order to obtain a detailed estimate of the current population.
- MLR data – Publically available 2011 Medical Loss Ratio Reporting Form data (MLR) is used in order to determine the current number of covered lives by insurance segment (Individual, Small Group, Large Group). This data also provides insight on claims and premiums per member per month (PMPM) for these insurance segments.

In addition to the data sources described above, the ***Milliman Health Cost Guidelines™*** (HCG) and ***Milliman Medical Underwriting Guidelines™*** (MUG) are utilized. These sources provide insight into items such as relative claims cost by age, gender, and health status. Pairing the HCG and MUG data with the publicly available data sources enables the Model to produce age/gender and morbidity estimates for the population.

Each of the data sources outlined plays a specific role in understanding the current population. The methodology implemented within the model is outlined below.

- The CPS data is utilized to estimate the percent of the population in Excellent, Very Good, Good, and Fair/Poor Health Status.
- ACS data is utilized to estimate the population breakdown by insurance coverage, age, gender, FPL, health status, and MSA.
- MLR data is used to understand the size of the insured markets (Individual, Small Group, Large Group), along with estimating current market claims PMPM.

The proportion of the population that will purchase coverage on the RIHBE is then estimated (i.e., "take-up"). These take-up rate assumptions are primarily driven by a member's current insurance status (i.e., insured or uninsured) and the federal subsidy available (if any) if the member enrolls in a plan on the RIHBE.

We then applied employer-sponsored insurance transition rates and individual/uninsured RIHBE take-up rates to estimate the population counts in each market (stratified by income-to-poverty ratio, health status, and family size). The result is a 2014 population projection by cohort (i.e., age, gender, income, and exchange status).

B. Step 2: Project NHPRI Enrollment by Market and Exchange Status

NHPRI's expected 2014 Individual enrollment was projected based on our estimate of the statewide population and market share estimates provided by NHPRI. As NHPRI will only be offering products on the RIHBE, it is assumed that no off exchange enrollment will exist. We estimated the members that would select each of NHPRI's benefit plans based on the plans for which they would qualify (given their age and income level). We also assumed that all 2014 members are enrolled for the entire year.

C. Step 3: Project Statewide Risk Scores For Use in the Risk Adjustment Transfer Payment

For the purpose of estimating NHPRI's risk adjustment transfer payment, the population projection model outlined in Step 1 was utilized to project statewide risk scores. This was completed by inferring the health status of the projected insured population by cohort using the self-reported health status field in the CPS data. Relative health status factors for each self-reported health status category, developed based on data available within the MUGs, were inferred based on the proportion of members within each self-reported health status category. These inferred relative health status factors were combined with age/gender claim cost factors from the HCGs to produce final statewide average risk scores for each population cohort.

D. Step 4: Project NHPRI's Risk Score For Use in the Risk Adjustment Transfer Payment

We assumed that NHPRI's risk scores for a given age, gender, and FPL cohort were comparable to the statewide average risk scores for the same cohort. This assumption relies on there being similar Selection and Coding Intensity between NHPRI and the statewide average. Selection refers to the health status difference between a given carrier and the overall market. Coding Intensity refers to a differing frequency and accuracy with which diagnosis codes are captured in claims data impacting the calculated risk score of the population. We did not model the impact of selection between the metal plans because carriers are not permitted to rate for selection.

E. Step 5: Estimate 2014 Statewide Average Claims for the Risk Adjustment Transfer Payments

To estimate the statewide premium in NHPRI's risk adjustment transfer payment, the statewide claim costs were estimated using 2011 Medical Loss Ratio Reporting Form (MLR) data. Blue Cross & Blue Shield of Rhode Island is the predominant carrier in Rhode Island, and as a result, was the focus of this portion of the analysis.

Statewide claim cost PMPM was calculated by adjusting for:

- Trend from 2011 to 2014,
- The pharmacy and device taxes,
- Health status changes due to uninsured individuals entering the insured market,
- Uninsured pent-up demand for medical services,

- Assumed "richness" of the plans and the resulting utilization patterns resulting from a given benefit design level, and
- Additional induced utilization for those enrolling in alternate Silver plans (i.e., those with cost sharing reductions).

When trending figures within the analysis, a consistent annual trend assumption of 5.8% was used for each year.

F. Step 6: Project NHPRI's 2014 Claim Costs

Since no experience is currently available for NHPRI, 2014 claim costs were developed using the ***Milliman Managed Care Rating Model*** (MCRM) and the ***Milliman Prescription Drug Rating Model*** (RXRM). These models were calibrated to reflect cost and utilization levels appropriate for NHPRI's assumed provider contracting arrangements and enrollment characteristics.

Specific considerations included:

- Reflecting NHPRI's assumed 2014 provider reimbursement rates,
- Reflecting NHPRI's assumed utilization rates,
- Adjusting the degree of healthcare management,
- Reflecting NHPRI's plan designs, and
- Reflecting results produced through the population modeling work, including assumptions for morbidity and pent-up demand.

These models were used in order to estimate utilization per 1,000 and average cost per service for the purpose of developing NHPRI's credibility manual. Finally, we projected claim costs PMPM for every combination of age, gender, metal plan, income level, and exchange status.

G. Step 7: Add Administrative Expenses

Administrative expenses were added to NHPRI's claim costs, including:

- General Administrative Expenses,
- Commercial Reinsurance Premium Net of Recoveries,
- Quality Improvement/Information Technology,
- Premium Tax,
- Comparative Effectiveness Research,
- Reinsurance Operating Fee,
- Risk Adjustment Admin Fee, and
- Contribution to Surplus.

Additional details related to administrative expenses can be found in Section XI, Non-Benefit Expenses and Profit & Risk.

H. Step 8: Add Estimated Federal Transitional Reinsurance Expenses

Additional costs or savings due to the Federal transitional reinsurance program were estimated. Differences exist between the markets since only the individual market is eligible for transitional reinsurance. It was assumed that NHPRI would pay $5.25 PMPM in reinsurance contributions. Reinsurance recoveries were estimated under the assumption that the individual market will receive 80% of all individual members' PMPY incurred claims between $60,000 and $250,000.

We estimated this value by calibrating claim probability distributions (CPDs) within the MCRM for each of NHPRI's individual benefit plans estimated PMPM claims.

Additional details related to Federal Transitional Reinsurance can be found in Section X, Risk Adjusters and Reinsurance.

I. Step 9: Estimate NHPRI's Risk Adjustment Transfer Payment

NHPRI's risk adjustment transfer payment was estimated using the CMS formula, which includes the statewide average premium, induced demand factor, geographical cost factor, NHPRI's risk score by plan, the plan's actuarial value, and allowable rating factors. The key determinant of whether NHPRI receives or makes a transfer payment is how NHPRI's risk score (normalized across all carriers) compares to the product of the actuarial value and allowable rating factors (normalized across all carriers).

The statewide average premium was estimated by adding expenses to the statewide average claim costs (i.e., Steps 5 and 7). Next, NHPRI's risk scores were normalized from Step 4 to the statewide average risk score by removing the portion of NHPRIs' risk score that can be accounted for through age rating factors, leaving an "uncompensated risk" factor. We then multiplied the "uncompensated risk" factor by the state average premium PMPM to estimate the net risk adjustment PMPM received or payable by NHPRI.

Additional details related to Risk Adjustment can be found in Section X, Risk Adjusters and Reinsurance.

J. Step 10: Calculate Composite Required Premium

The composite required premium was calculated by summing expected claims, administrative expenses, the net impact of federal reinsurance, and the net impact of state risk adjustment. An additional load was added to account for family policies with more than three members under the age of 21. Lastly, it was verified that no expected minimum loss ratio rebates or risk corridor payments we estimated to result from the established premium rates.

K. Step 11: Calculate Premiums by Rate Cell

The composite required premium was divided by the composite of all allowable rating factors across NHPRI's projected block of business by rating cell to determine a base rate. This base rate, in combination with the allowable rating factors, will result in the premium rates charged to enrollees in 2014.

Age and plan design are the only allowable rating factors for each cohort in Rhode Island. We developed NHPRI's rating factors to meet the regulatory requirements below:

- Age factors as specified by law, and
- Plan factors based on the plan's actuarial value, cost sharing utilization, network, and cost of administration.

VIII. CREDIBILITY OF EXPERIENCE

Since no experience data is available, a credibility assumption of 0% was applied. The manual rates developed through the steps outlined under Section VII are the sole basis for the premium rates proposed in this memorandum.

IX. PAID TO ALLOWED RATIO

The paid to allowed ratio provided in Worksheet 1, Section III of the Unified Rate Review Template (URRT) and in "II Data Collection" of the 2013 Rate Review Process OHIC Template was developed using the MCRM and RXRM models calibrated for the purpose of developing NHPRI's manual rates. These models were used to develop both paid and allowed claims on a per member per month (PMPM) basis for every combination of age, gender, metal plan, income level, and exchange status. The resulting paid and allowed claims PMPM were weighted based on NHPRI's membership projections in order to arrive at an estimated paid to allowed ratio. While utilization differences were considered for the CSR eligible population, the benefits reflected within the paid claim PMPM estimates reflected a silver level of coverage for individuals assumed enrolled in CSR plans.

X. RISK ADJUSTERS AND REINSURANCE

The processes used to estimate risk adjustment and reinsurance were completed in Steps 9 and 8 of the premium development process respectively.

A. Risk Adjustment Transfer Payment Estimate

NHPRI's risk adjustment transfer payment was estimated using the CMS formula, which includes the statewide average premium, induced demand factor, geographical cost factor, NHPRI's risk score by plan, the plan's actuarial value, and allowable rating factors. The key determinant of whether NHPRI receives or makes a transfer payment is how NHPRI's risk score (normalized across all carriers) compares to the product of the actuarial value and allowable rating factors (normalized across all carriers).

The statewide average premium was estimated by adding expenses to the statewide average claim costs produced in the premium development process (Steps 5 and 7). Next, NHPRI's risk scores (from Step 4 of the premium development process) were normalized to the statewide average risk score and the portion of NHPRIs' risk score that can be accounted for through age rating factors was removed; leaving an "uncompensated risk" factor. We then multiplied the "uncompensated risk" factor by the state average premium PMPM to estimate the net risk adjustment PMPM received or payable by NHPRI.

NHPRI's target population in the individual market includes lower income individuals eligible to receive subsidies. It is assumed that lower income individuals have a higher risk compared to higher income individuals. With this in mind, we are estimating NHPRI to receive risk adjustment payments. The estimated PMPM risk adjustment received by NHPRI was aggregated in order to determine the appropriate impact as a percent of premium. The process resulted in an estimated risk adjustment premium impact of approximately -3% (-$11.06 PMPM). Premium rates developed for NHPRI were thus reduced by this percentage in order to appropriately reflect the estimated risk adjustment transfers.

B. Federal Transitional Reinsurance Estimate

Additional costs or savings due to the Federal transitional reinsurance program were estimated. Differences exist between the markets since only the individual market is eligible for transitional reinsurance. It was assumed that NHPRI would pay $5.25 PMPM in reinsurance contributions. Reinsurance recoveries were estimated under the assumption that the individual market will receive 80% of all individual members' PMPY incurred claims between $60,000 and $250,000.

We estimated this value by calibrating claim probability distributions (CPDs) within the MCRM for each of NHPRI's individual benefit plans estimated PMPM claims.

This calculation was performed separately for each combination of age, gender, metal plan, income level, and exchange status. In order to appropriately allocate estimated reinsurance payments, the PMPM results were aggregated to estimate the impact as a percent of premium. Before reflecting reinsurance contributions, Federal transitional reinsurance resulted in an approximately 10% reduction to premium (-$39.27 PMPM). This figure drops to approximately 9% (-$34.02 PMPM) after reflecting the contributions NHPRI is estimated to pay.

XI. NON-BENEFIT EXPENSES AND PROFIT & RISK

The proposed rates reflect an administrative load of approximately 20% including General Administrative Expenses, Contribution to Surplus, Taxes and Fees. This load was developed through the use of assumptions provided to Milliman from NHPRI.

A. Administrative Expense Load

The table below outlines the Administrative Expenses that are reflected in the proposed premium rates. These expenses were developed using assumptions provided to Milliman from NHPRI. All categories are demonstrated as both a PMPM and percent of premium. However, please note that some items were developed and applied on a different basis. In these situations, items have been converted to PMPM equivalents or Percent of Premium equivalents as needed for illustrative purposes.

Table 1: Administrative Expenses

Description	PMPM Equivalent	Percent of Premium
General Administrative Expense	$ 39.35	10.2%
Commercial Reinsurance Net of Recoveries	$ 1.75	0.5%
Quality Improvement	$ 7.20	1.9%
Additional Child Load	$ 3.50	0.9%

NHPRI will not be paying any broker commissions and, as such, administrative expenses associated with commissions are not reflected. The Additional Child Load is intended to reflect that rates for family policies cannot account for more than three members under the age of 21. A portion of this load will be reflected in claims experience in subsequent years (approximately 0.7%), while the remaining portion is intended to account for additional administrative expenses associated with these members.

B. Contribution to Surplus & Risk margin

The proposed rates reflect 3% of premium being allocated to Contribution to Surplus & Risk Margin. This load was applied evenly to all plans being offered by NHPRI.

C. Taxes and Fees

The table below outlines the Taxes and Fees that are included in the non-benefit expenses.

Table 2: Taxes and Fees

Description	PMPM Equivalent	Percent of Premium
Premium Tax	$ 7.73	2.00%
Comparative Effectiveness Research	$ 0.17	0.04%
Reinsurance Operating Fee	$ 0.11	0.03%
Risk Adjustment Admin Fee	$ 0.08	0.02%

It is currently understood that there will be no Exchange Operation Fees in Rhode Island for calendar year 2014. Additionally, it is assumed that NHPRI will not be assessed the Health Insurer Tax provided that over 80% of premiums are received for Medicaid.

XII. PROJECTED LOSS RATIO

The projected loss ratio for NHPRI's Individual bock of business is approximately 86.7%. This loss ratio is calculated consistently with the Federally prescribed MLR methodology, and reflects the projected loss ratio prior to reflecting any applicable credibility adjustments. A credibility adjusted loss ratio is estimated at approximately 91.0% based on membership projections developed by Milliman with guidance from NHPRI.

XIII. INDEX RATE

No experience data was made available as NHPRI current does not offer plans in the commercial health insurance market. As such, an index rate for the experience period was not calculated.

For the projection period, the index rate was calculated using information produced during the premium rate development process. The index rate provided reflects the estimated total allowed claims divided by total projected member months. The estimate produced reflects the utilization level, demographics, etc. of NHPRI's assumed enrollment. There will be no non-essential health benefits included in NHPRI plans. Because of this, the index rate provided aligns with the projected allowed claims PMPM.

In order to arrive at each plan's rate level based on the projected index rate, adjustments for the following items are considered:

- Cost sharing structure of the plan,
- Assumed cost sharing utilization of the plan, and
- Administrative costs.

All plans offered have a consistent provider network, utilization management, and delivery system. Additionally, items such as risk adjustment and reinsurance are accounted for consistently on all plans. Also, as previously noted non-essential health benefits will not be offered. Assumptions for cost structure and utilization differences by plan are outlined within Section XV, AV Pricing Values.

XIV. AV METAL VALUES

In the Individual market, NHPRI intends to offer two plans along with their corresponding CSR and Indian Cost-Sharing permutations.

Specifically, plans to be offered include the following:

- One plan at the Gold metal level,
- One plan at the Silver metal level,
- Three CSR plans to correspond with the Silver offering,
- One Zero Cost-Sharing plan for Indian's under 300% of FPL, and
- Two Limited Cost-Sharing plans for Indians to correspond with the Gold and Silver plans.

The AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template were based on the Federal AV Calculator. No adjustments to plan cost sharing were needed in order to determine AV using the Federal AV Calculator. While the Federal AV Calculator does not contain an input for every potential variation in plan designs, it is assumed that the majority of variation between AVs is being captured by the plan characteristics available within the Federal AV Calculator. This assumption is consistent with documentation provided within the Actuarial Value Calculator Methodology document made available by the Department of Health and Human Services.

XV. AV PRICING VALUES

AV pricing values were developed based on the allowable rating factors for each cohort in Rhode Island. In order to be consistent with the OHIC rate review process, the premium of a plan covering 100% of allowed costs for a 21-year old assuming Silver Metal Level utilization was calculated as the fixed reference plan for basis of the AV Pricing Values. We developed NHPRI's rating factors to meet the regulatory requirements below:

- Age factors as specified by law, and
- Plan factors based on the plan's actuarial value, cost sharing utilization, network, and cost of administration.

There are no assumed network differences between the plans being offered by NHPRI. Also, administrative costs are assumed to be consistent for each offering. However, certain administrative costs are developed on a PMPM basis and thus when demonstrated as a percent of premium they may vary.

The MCRM model calibrated for the purpose of developing NHPRI's manual rates was utilized for developing NHPRI's AV Pricing Values. This MCRM model is based on data from the ***Milliman Health Cost Guidelines™*** (HCGs). The HCGs provide a flexible but consistent basis for the determination of claim costs for a wide variety of health benefit plans. These rating structures are used to anticipate future claim levels, evaluate past experience and establish interrelationships between different benefit levels.

The HCGs are developed as a result of Milliman's continuing research on health care costs. They were first developed in 1954 and have been updated and expanded annually since then. These guidelines are continually monitored as we use them in measuring the experience or evaluating the rates of our clients and as we compare them to other data sources.

The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research and judgment. An extensive amount of data is used in developing these guidelines, including published and unpublished data. In most instances, cost assumptions are based upon our evaluation of several data sources and, hence, are not specifically attributable to a single source. Since these guidelines are a proprietary document of Milliman, they are only available for release to specific clients that lease these guidelines and to Milliman consulting health actuaries.

We used the calibrated MCRM model to estimate the value of cost-sharing and relative utilization of services for each plan. Our pricing models assume the same demographic and risk characteristics for each plan priced, thereby excluding expected differences in the morbidity of members assumed to select the plan.

The table below includes AV Pricing Values for the two plans offered on the Individual market. Factors are shown separately for utilization and relative AV, the product of which produces the proposed AV Pricing Value.

Table 3: Cost Sharing Utilization Factor by Metal Level

Metal Level	Cost Sharing Utilization Factor	Relative AV Factor	AV Pricing Value
Gold	1.06	0.82	0.87
Silver	1.00	0.75	0.75

For individuals enrolled in the 87% or 94% CSR plans, it was assumed that utilization will be 12% higher consistent with CMS guidance. It is assumed that NHPRI's membership will predominantly consist of CSR eligible individuals. The impact associated with CSR utilization is being applied evenly across all plan designs and metal level offerings.

XVI. MEMBERSHIP PROJECTIONS

The membership projections were developed in conjunction with NHPRI. These projections reflect market share estimates assumed by NHPRI. Additionally, the projections reflect the total market size estimated in Step 1 of the premium development process.

The population projection modeling completed in the premium rate development process was used to determine the proportion of NHPRI membership that would be eligible for CSR plans. Membership by plan and subsidy level is outlined in the table below.

Table 4: Membership by Plan and Subsidy Level

Plan	Membership
Gold	0
Silver (94% CSR)	740
Silver (87% CSR)	3,150
Silver (73% CSR)	1,819
Silver (70%)	0
Total	**5,709**

XVII. TERMINATED PRODUCTS

Not applicable. No plans are being terminated as NHPRI currently does not offer products in the Individual market.

XVIII. PLAN TYPE

Not applicable. The plan types listed in Worksheet 2, Section I of the Part I Unified Rate Review Template appropriately describe NHPRI's plans.

XIX. WARNING ALERTS

The following differences between the plan-level projections in Worksheet 2 and the total projected amounts found in Worksheet 1 were noted.

Explanations regarding these differences are as follows:

- A warning is listed in cell A82 of Worksheet 2, Plan Product Info. This warning is the result of rounding differences between values listed within the workbook. Total Premium is appropriately aligning to the nearest dollar.
- A warning is listed in cell A99 of Worksheet 2, Plan Product Info. This warning appears to be due to the template checking total allowed claims before reinsurance and risk adjustment to a calculation that represents total allowed claims after these items.

XX. EFFECTIVE RATE REVIEW INFORMATION

The following section contains additional information and documentation pertaining to the 2013 Rate Review Process OHIC Template.

As previously indicated, experience data was not available for the purpose of developing premium rates for NHPRI's products. Because of this, some sections of the OHIC Template have been intentionally left blank. Additionally, methodologies utilized for rate development purposes are consistent with those described in prior sections of the document. This section is intended to capture documentation for information not included within the Part I Unified Rate Review Template.

A. Experience Data

- **Part 1. Historical Information**
  Since no experience data was available, Part 1 has not been completed.
- **Part 2. Prospective Information**
  Since no experience data was available, sections A and C have not been completed. Section B was completed using assumptions consistent with the premium rate development process outlined in Section VII of this memorandum. The Expected Pure Medical Cost Ratio was calculated as estimated total claims PMPM divided by projected total premium PMPM. This calculation is not intended to be consistent with the Federally prescribed MLR methodology. Administrative cost percentages are consistent with values shown in Section XI of this memorandum, yet are allocated to the prescribed categories.

B. Data Collection

Information contained in this section and corresponding documentation is consistent with values shown within the Part I Unified Rate Review Template; however, it contains two additional items.

- **Base EHB Rate for Projection Period**

This value was calculated by adjusting the Index Rate to reflect the premium of a plan covering 100% of allowed cost for a 21-year old enrollee assuming Silver Metal Level utilization. To accomplish this, composite age and cost sharing utilization factors were calculated.

A description of the methodology used to calculate cost sharing utilization factors is available within Section XV of this memorandum. Additional supporting calculations have been provided within the 2013 Rate Review OHIC Template.

- **Monthly Effective Date Projection Factor**

This section is not applicable for the Individual market.

Additionally, the information requested in rows 47 and 48 of this tab is not identical to the corresponding section of the Part 1 Unified Rate Review Template. The primary difference is that the Federal template requests 'Taxes & Fees' while the 2013 OHIC Template specifically requests 'Premium Tax'. To account for this variation, Taxes and Fees other than Premium Tax have been included in the 'Administrative Expense Load' field.

C. Plan Rates

All products are new for 2014; therefore, 2013 values have been left blank within this template. Metallic Tier Actuarial Value was calculated in an identical manner as outlined in Section XIV, AV Metal Values. AVs provided within this section align with values shown in Worksheet 2 of the Part I Unified Rate Review Template. Additionally, the Proposed Plan Relativity Factors are consistent with the values outlined in Section XV, AV Pricing Values. A description and supporting information for these values can be found within that portion of this memorandum.

Membership for 1/1/2014 was estimated using membership projections as outlined in XVI, Membership Projections. As outlined within the premium development process, publically available survey data was used for the purpose of understanding the current population. Projections were performed at the member level as data was not made available at the group and/or subscriber level in the available survey data. For this reason, columns R and S have not been completed.

The proposed base rate PMPM reflects the premium of a plan covering 100% of allowed claims for a 21-year old enrollee with utilization set at the Silver Metal Level. This figure aligns with the base EHB rate shown in the second tab of the template. Pediatric Dental benefits will not be offered. Each member's rate can be calculated as the product of the EHB Base Rate, the AV Pricing Value, and the appropriate Age Factor. Please note that AV Pricing Values were developed in a different manner, yet presented as a percentage of the EHB Base Rate for filing purposes.

D. Administrative Costs

As outlined in Section XI of this memorandum, administrative costs were developed through the use of assumptions provided to Milliman from NHPRI. Prior year administrative cost data is not available due to NHPRI currently not offering products in the commercial market. Administrative costs were broken down in to the applicable categories through the use of assumptions provided to Milliman from NHPRI.

It is currently understood that there will be no Exchange Operation Fees in Rhode Island for calendar year 2014. Additionally, it is assumed that NHPRI will not be assessed the Health Insurer Tax provided that over 80% of premiums are received for Medicaid.

Additional details related to administrative costs can be found in Section XI, Non-Benefit Expenses and Profit & Risk.

XXI. RELIANCE

In developing the premium rates in this actuarial memorandum, I relied on data and other information provided by NHPRI. I have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of the analysis may likewise be inaccurate or incomplete. I performed a limited review of the data used directly in the analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of my assignment.

XXII. ACTUARIAL CERTIFICATION

I, Jeremy D. Palmer, am a member of the American Academy of Actuaries and meet its qualification standards for actuaries issuing statements of actuarial opinion in the United States. I have been retained by Neighborhood Health Plan of Rhode Island (the "Company") to prepare this filing.

I am affiliated with Milliman, Inc. ("Milliman"), an independent actuarial consulting firm that is not affiliated with, nor a subsidiary, nor in any way owned or controlled by a health plan, health insurer, or a trade association of health plans or insurers.

I hereby certify that the projected index rate is, to the best of my knowledge and understanding:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)).
- Developed in compliance with the applicable Actuarial Standards of Practice.
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Neither excessive nor deficient.

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates. The allowable modifiers used to generate plan-level rates were:

- The actuarial value and cost-sharing design of the plan.
- The plan's provider network, delivery system characteristics, and utilization management practices.
- Administrative costs, excluding Exchange user fees.

I certify that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with relevant actuarial standards of practice.

I certify that the benefits included within Neighborhood's plans are substantially equivalent to the Essential Health Benefits (EHBs) in the State of Rhode Island's benchmark plans. I certify that any benefit substitutions are:

- Actuarially equivalent to the benefits being replaced,
- Are made within only the same essential health benefit category,
- Are based on a standardized plan population,
- Are determined regardless of cost-sharing,

- Are not prescription drug benefits, and
- Are based on an analysis performed in accordance with generally accepted actuarial principles and methodologies.

I certify that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans except those specified in the certification. The AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template were based on the Federal AV Calculator. No adjustments to plan cost sharing were needed in order to determine AV using the Federal AV Calculator. While the Federal AV Calculator does not contain an input for every potential variation in plan designs, it is assumed that the majority of variation between AVs is being captured by the plan characteristics available within the Federal AV Calculator. This assumption is consistent with documentation provided within the Actuarial Value Calculator Methodology document made available by the Department of Health and Human Services.

The Part I Unified Rate Review Template and the 2013 Rate Review Process OHIC Template do not demonstrate the process used by Milliman to develop the rates. Rather, it represents information required by Federal and State regulations to be provided in support of the review of rate increases, for certification of qualified health plans that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Electronic Signature

Jeremy D. Palmer, FSA, MAAA
Principal and Consulting Actuary

April 12, 2013
Date

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Issuer and Plan Compliance Attestation
Forms
Individual and Small Group Markets

Health Insurance Issuer name: NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND

Health Insurance Plan name: EXCHANGE PRODUCT 2014 - INDIVIDUAL MARKET

SERFF form tracking number: NHRI - 128913451

I, T. Clark Phillip, am a duly authorized officer of the above-identified Health Insurance Issuer ("Issuer") of an individual health insurance plan, or of a small group health insurance plan. I do hereby attest that I am knowledgeable as to the current federal and state laws and regulations applicable to the above-identified Health Insurance Plan ("Plan"). To the best of my knowledge and belief, I hereby attest that the Plan is in compliance with such federal and state laws and regulations.

Furthermore, I hereby attest and swear under oath that:

Form Attestations

1. The filing complies with federal and state laws and regulations, and does not contain inconsistent, ambiguous, unfair, inequitable, or misleading clauses, or exceptions of conditions that unreasonably affect the risk purported to be assumed.
2. The Issuer's highest enrollment product line across both the individual and small group markets, and each of the Issuer's product lines offered on the Rhode Island Health Benefits Exchange, is accredited by an accrediting agency approved by federal regulations. Evidence of compliance is attached as Exhibit A (e.g. a copy of the agency's accreditation determination). If the foregoing cannot be attested to, an attachment to this Attestation describes the status of the Issuer's accreditation application, and the date no later than January 1, 2015 when accreditation is anticipated to be awarded. The term "product line" means the benefit design category of a set of health benefit plans, including but not limited to a Point of Service product line, a Preferred Provider Organization product line, and a Health Maintenance Organization plan product line.
3. The Issuer is in compliance with federal laws and regulations relating to network adequacy and provider directories.
4. The Issuer is in compliance with Rhode Island Department of Health network adequacy standards, as set forth in the letter from Director Michael Fine, MD to Commissioner Koller and Director Ferguson dated January 11, 2013. Evidence of compliance is attached as Exhibit B (e.g. a general statement of the

manner in which the Issuer has achieved compliance with DOH network adequacy standards, as set forth the Director Fine's letter).

5. The Issuer is in compliance with federal and state laws and regulations relating to utilization review, grievances, internal appeals, and external appeals.
6. The Issuer is in compliance with federal laws and regulations relating to consumer disclosure and the required summary of benefits and coverage. Evidence of compliance is attached as Exhibit C (e.g. a statement identifying the applicable consumer disclosure requirements, a general statement of compliance with such requirements, and a mechanism to review the required summary of benefits and coverage for the Plan).
7. The Issuer is in compliance with federal requirements concerning non-discrimination of plan offerings in all locations of the state.
8. The Issuer is in compliance with federal requirements prohibiting discrimination with respect to health care providers, as provided for in 42 U.S.C. § 300gg-5.
9. Issuer is in compliance with federal requirements relating to non-discrimination, as provided for in 45 C.F.R. § 156.200(e).
10. Issuer is in compliance with federal and state standards relating to an issuer's obligations to subscribers and insureds with respect to termination of enrollment, notice of termination, nonpayment of premium, notice of nonpayment of premium, and grace periods for nonpayment of premium.

The Issuer, and the Officer attesting on behalf of the Issuer, hereby acknowledge that: (i) the Office of the Health Insurance Commissioner has relied on this Attestation in reviewing this filing, and (ii) should it be determined that an approved filing is materially false, misleading, or incorrect in any manner, appropriate corrective and disciplinary action, as authorized by the Commissioner, may be taken against the Issuer and the Officer completing this Certification, including but not limited to perjury proceedings. R.I. Gen. Laws § 42-14-11(c).

Subscribed and sworn to under oath this 27th day of February, 2013.

Signature of Officer attesting on behalf of the Issuer: T Clark Phillip

Date of Signature: 2/27/13

Printed Name: T. Clark Phillip

Title: Chief Financial Officer

Mailing Address: 299 Promenade Street, Providence, RI 02908

Direct Telephone Number: (401) 459-6611

Email Address: cphillip@nhpri.org

Michelle Letreault
Notary Public

Notary Public

Checklist for Individual and Small Group Health Insurance Plans - Policy Form
Inside and Outside the Rhode Island Health Benefit Exchange
Effective for plan years beginning on and after 1-1-2014

Company Name Neighborhood Health Plan of Rhode Island

Product Name: Neighborhood Health Plan Exchange Product 2014 – Individual Market

Plan Name: XXXX

Issuer is:
☐ certified by the Health Benefits Exchange as a QHP issuer
X licensed by OHIC to do health insurance business in RI

SERFF tracking number: NHRI-128972321
TOI Code and Sub Code: H16I – Individual Health – Major Medical
H16G.005C Individual Other

☐60% AV (Bronze)
X 70% AV (Silver)

X 80% (Gold)
☐ 90% (Platinum)
☐ Child-only
☐ Catastrophic Plan - 42 U.S.C. § 18022(e)

Filed for issuance: Inside the Exchange X Outside the Exchange ☐ Inside and Outside the Exchange ☐
Individual Market X Small Group Market☐SHOP ☐ ☐

Instructions for Checklist:

A. The Checklist for Individual and Small Group Health Insurance Plans ("Checklist") must be completed for all major medical health insurance plan policy forms offered by a health insurance issuer (“Issuer”) in the individual market and in the small group market, including individual Qualified Health Plans (“QHP’s”) and SHOP QHP’s offered on the Rhode Island Health Benefit Exchange (“Exchange”).
B. The Checklist does not apply to large group health insurance plans, dental plans, or Medicare Supplemental insurance plans.
C. The terms of applicable laws and regulations shall supersede this Checklist in the case of a conflict. The omission of any requirement of the law or of a regulation from this Checklist in no way limits the authority of the Office of the Health Insurance Commissioner to enforce any other such requirement.
D. A filer shall not change or revise the Checklist.
E. By checking the "Yes" box, the Issuer certifies that the referenced provision of the health insurance plan ("Plan") complies with the associated requirement, and that the referenced provision does not contain any inconsistent, ambiguous, unfair, inequitable, or misleading clauses, or exceptions of conditions that unreasonably affect the risk purported to be assumed.

F. By checking the box "N/A", the Issuer certifies that Plan does not have to comply with the associated requirement. An Explanation must be provided if this box is checked.

G. This Checklist is established by the Commissioner of the Office of the Health Insurance Commissioner ("OHIC") pursuant to OHIC Regulation 17 - "Filing and Review of Health Insurance Plan Forms and Rates." The Checklist is intended to communicate the Commissioner's considered opinion concerning what a Plan form must contain in order to satisfy the statutory and regulatory standards for approval of the form. See R.I. Gen. Laws §§ 27-18-8, 27-19-6, 27-20-6, and 27-41-29.2.

H. The Commissioner may revise the Checklist from time to time. The Checklist, and any revisions to the Checklist, will be posted on SERFF as Filing Instructions for Rhode Island.

I. The filing shall include an actuarial memorandum demonstrating the calculation and analysis used to determine: (a) the Plan's actuarial value rating, and if applicable, (b) the Plan's Catastrophic Plan status, (c) the actuarial equivalence of Essential Health Benefit substitutions, and (d) the conversion of annual or lifetime dollar limits for Essential Health Benefits to a permitted limitation.

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
General Requirements				
1. The filing must contain the entire health insurance plan policy form. • If the filer requests approval of any section, paragraph or other text in the Plan based on prior approval of the text by OHIC, the filer must identify the previously approved filing, and the page, section and paragraph where the text appears in the previously approved filing.	RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2. OHIC Regulation 17		X ☐	☐ X
Explanation: This is Neighborhood's first Certificate of Coverage and has not been previously approved by OHIC .				
2. If changes to a previously approved form are filed, the filing shall include a red-lined version of the previously approved form, and a clean version of the form as proposed to be amended.	RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2. OHIC Regulation 17		☐	X
Explanation: This is Neighborhood's first Certificate of Coverage and has not been previously approved by OHIC				
3. All forms must be filed in a word-searchable format.	RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2 OHIC Regulation 17		X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
Explanation:				
4. Readability. • Forms must comply with the requirements of OHIC Regulation 5, "Standards for the Readability of Health Insurance Forms". • The filing must include a Readability Certification in accordance with OHIC Regulation 5.	45 CFR §156.265(e) RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2 OHIC Regulation 5		X X	☐ ☐
Explanation:				
5. The filing must include the "Compliance Attestation - Forms", attached hereto as Exhibit A.	RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2. OHIC Regulation 17.	Attestation Forms Filed Separately in SERFF On 4/15/2013	X	☐
Explanation:				
Standard Policy Provisions 6. The Plan complies with state laws and regulations relating to: • The Form of the Plan. • Required Provisions • Individual Health Benefit Contracts • Group and Blanket Health Benefit Contracts	 R.I. Gen. Laws § 27-18-2 R.I. Gen. Laws § 27-18-3 OHIC/DBR Regulation 23, Part VII OHIC/DBR Regulation 23, Part VIII	 p. 6-8, Ch. 1, §2.2 pp. 112-116, Ch. 8, §§1-3 pp. 36-38, Ch. 4, §2.1 p. 143, Ch. 10 p. 112, Ch. 8, §1 p. 36, Ch. 4, §2.1	 X X X X	 ☐ ☐ ☐ ☐
Explanation:				

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
Form Content Requirements X				
7. Essential Health Benefits ("EHB") a) The Plan must cover each of the 10 categories of Essential Health Benefits: o Ambulatory patient services o Emergency services o Hospitalization o Maternity and newborn care o Mental health and substance use disorder services, including behavioral health treatment o Prescription drugs o Rehabilitative and habilitative services and devices o Laboratory services o Preventive and wellness services and chronic disease o Pediatric services, including oral and vision care	42 U.S.C. § 18022 45 C.F.R. § 156.100 et seq.	pp viii-xiv - Summary of Benefits pp. 36-65, Ch. 4, §§ 2 & 3	X	☐
b) The provisions of this Section 7 apply to benefits and services covered under the Plan. The provisions of this Section 7 do not apply to cost sharing, and do not apply to utilization review standards and procedures.				
c) The Plan must cover each and every service covered in the EHB-Benchmark Plan. The components of the EHB-Benchmark Plan are: (1) the Blue Cross Vantage Blue Small Group plan ("the Base-Benchmark Plan"), including the prescription drug benefits covered by the Base-Benchmark Plan; (2) the pediatric dental benefits covered under the MetLife Federal Dental plan; (3) the pediatric vision benefits covered under the FEP Blue Vision plan; and (4) habilitative services as determined and required by subsection (h), below. Note: OHIC considers each of the benefits and services covered in the Base-Benchmark Plan to be included within one of the 10 Essential Health Benefits listed in subsection		pp viii-xiv - Summary of Benefits pp. 36-65, Ch. 4, §§ 2 & 3	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
(a), above. If the filer proposes to exclude a benefit or service covered in the R.I. Benchmark Selections, because the filer considers the benefit or service to be not included within one of the 10 Essential Health Benefits listed in subsection (a), above, the filer must identify such benefit or services, and provide a written explanation for the exclusion. The components of the EHB-Benchmark Plan (other than habilitation services required by subsection (h), below, can be found at the following address on the OHIC website: http://www.ohic.ri.gov/2010%20Health_Reform.php				
d) The Plan must cover the services covered in the EHB-Benchmark Plan, including but not limited to each and every state benefit mandate covered in the Base-Benchmark Plan.		pp viii-xiv - Summary of Benefits pp. 36-65, Ch. 4, §§ 2 & 3	X	☐
e) Prescription drugs. ○ The filer must include the Plan's prescription drug formulary with the filing. ○ The Plan must cover the greater of: (i) one drug in each United States Pharmacopeia ("USP") category or class, or (ii) the same number of prescription drugs covered in the Base-Benchmark Plan. ○ The Plan may substitute a prescription drug covered under the Base-Benchmark Plan, provided that the substituted drug covered under the Plan is in the same USP category or class as the drug covered under the Base-Benchmark Plan. The Issuer shall identify any drug substitutions, and shall verify that the therapeutic category or class of the substituted drug covered under the Plan is the same as the therapeutic category or class of the drug covered under the Base-Benchmark Plan. In the case of formulary substitutions during the Plan year, the Issuer shall file on SERFF a notification (not subject to prior approval) identifying the substitution that has		pp. 61-65, Ch. 4, §3	X X X	☐ ☐ ☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
been made, and verifying that the USB category or class of the substituted drug covered under the Plan is the same as the USP category or class of the drug covered under the Base-Benchmark Plan. ○ The Plan shall describe the process for an enrollee to request and receive coverage of clinically appropriate drugs not on the Plan's formulary.		p. 64, Ch. 4, §3.2	X	☐
f) A Plan that is offered outside the Exchange must cover the pediatric dental services covered by the EHB-Benchmark Plan (the MetLife Federal Dental plan for federal employees), for enrollees 18 years of age or younger; except that a Plan that is offered outside the Exchange is not required to cover the pediatric dental services covered by the EHB-Benchmark Plan if the Issuer determines, after reasonable inquiry, that the individual or small group policyholder is covered under a dental insurance plan that covers the pediatric dental services covered by the EHB-Benchmark Plan. If the individual or small group policyholder is already covered under a dental insurance plan that covers the pediatric dental services covered by the EHB-Benchmark Plan, the Issuer shall not offer the Plan with pediatric dental services; instead, the Issuer must offer a Plan that excludes pediatric dental coverage, with a premium discount equivalent to the per member per month cost of pediatric dental coverage. The Issuer's rate filing for the Plan shall include the proposed premium for the Plan with and without pediatric dental services.		Plan will not be offered outside the Exchange; therefore no Pediatric Dental is required.	☐ X	X ☐
g) The Plan must cover the pediatric vision services covered under EHB-Benchmark Plan (the FEP Blue Vision plan for federal employees) for enrollees 18 years of age or younger.		pp 47-50, Ch. 4, §2.1	X	☐
h) The Plan must cover habilitative services as approved by the Commissioner, in accordance with the following: Habilitative services covered under the Plan must be defined by scope, and		p. 46, Ch. 4, §2.1 p. 133, Ch. 10	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
must be at least as comprehensive (measured by per member per month cost) as the per member per month cost of rehabilitation services covered under the plan. Service visit limitations or other durational or quantitative limitations will be approved by the Commissioner only if the filer can demonstrate that no other qualitative, evidenced-based limitations less burdensome to the consumer (e.g. a process for developing limitations based on individual assessments of need) are feasible and appropriate. The filer must attach in the filing an Exhibit that (1) identifies the habilitative services covered by the plan, (2) includes an actuarial memorandum estimating the per member per month cost of the habilitative and rehabilitative services covered, and (3) includes in the actuarial memorandum the calculation and analysis used to develop the identified cost. No later than 90 days after the end of each calendar year, the Issuer must file with OHIC an actuarial memorandum, using the best available claims data, describing the Plan's claims and expense experience for habilitative and rehabilitative services during the preceding Plan year, and comparing such claims and expense experience with the approved rate factor.		Neighborhood is not placing a limit on Habilitative Services	X	☐
			X	☐
i) Substitutions. o A Plan may substitute a benefit or service for a benefit or service covered under the EHB-Benchmark Plan only if: (1) the Plan's substitute benefit or service is included within the same Essential Health Benefit category (see subsection (a), above) as the benefit or service covered under the EHB-Benchmark Plan; (2) the substitute benefit or service and the substituted benefit or service are actuarially equivalent; and (3) the substitution is approved by the Commissioner. o The filer must identify the substitution, and must file an actuarial memorandum demonstrating that the substitution is actuarially equivalent.		No substitution proposed	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
j) A Plan may include a material deviation from a benefit or service for a benefit or service covered under the EHB-Benchmark Plan only if (1) the deviation is identified; (2) the Issuer files a memorandum demonstrating that the deviation is substantially equivalent to the EHB-Benchmark Plan; and (3) the deviation is approved by the Commissioner.		No material deviations proposed	X	☐
Explanation:				
8. Cost-sharing. • Out of pocket limits. The Issuer must demonstrate in an Exhibit filed with the Plan that annual out of pocket cost sharing under the Plan does not exceed the limits established by federal and state laws and regulations, including any revisions to this Checklist. • Deductible limits. For small group Plans, the Issuer must demonstrate in an Exhibit filed with the Plan that annual deductibles under the Plan do not exceed the limits established by federal and state laws and regulations, including any revisions to this Checklist.	42 U.S.C. § 18022(c) 45 C.F.R. § 156.130(a)	pp viii-xiv - Summary of Benefits pp. 34-35, Ch. 4, § 1.3	X X	☐ ☐
Explanation:				
9. The Plan must contain no preexisting condition exclusions.	42 U.S.C. § 300gg-3 RI Gen Law §§ 27-18-71, 27-18.5-10, 27-19-68, 27-20-57, 27-41-81	pp. 86, Ch.6, §1.1 pp. 93, Ch.6, §1.6	X	☐
Explanation:				

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
10. Lifetime dollar limits. • The Plan must contain no lifetime limits on the dollar value of any Essential Health Benefits, including the specific benefits and services covered under the EHB-Benchmark Plan. See Para. 7, above. • If the specific benefits and services covered under the Base-Benchmark Plan (See Para. 7, above) include dollar limits on the coverage of any such benefit or service, the Plan may propose an actuarially equivalent conversion of the dollar limit to a utilization limit, or some other quantitative or qualitative limit, subject to the Commissioner's approval. • If the Plan proposes a conversion the Issuer must file with the Plan an actuarial memorandum supporting the actuarially equivalent conversion.	PHSA §2711 45 CFR §147.126 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2	Infertility p. 42, Ch.4, §2.1 Low Vision p. 50, Ch.4, §2.1	X ☐	☐ X X
Explanation: **Plan does not include any lifetime dollar or utilization limits for EHB**.				
11. Annual dollar limits. a) The Plan must contain no lifetime limits on the dollar value of any Essential Health Benefits, including the specific benefits and services covered under the EHB-Benchmark Plan. See Para. 7, above. b) If the specific benefits and services covered under the Base-Benchmark Plan (See Para. 7, above) include dollar limits on the coverage of any such benefit or service, the Plan may propose an actuarially equivalent conversion of the dollar limit to a utilization limit, or some other quantitative or qualitative limit, subject to the Commissioner's approval. c) If the Plan proposes a conversion the Issuer must file with the Plan an actuarial memorandum supporting the actuarially equivalent conversion.	42 U.S.C. § 300gg-11 45 CFR §147.126 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2	Low Vision p. 50, Ch.4, §2.1 Prosthetic Devices p. 60, Ch.4, §2.1 Early Intervention Services p. 41, Ch.4, §2.1	X X ☐	☐ ☐ X
Explanation: **Plan does not include any annual dollar or utilization limits for EHB**				

Requirement	Federal & State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
12. The Plan must state that the Issuer may not rescind the Plan except in cases of fraud or intentional misrepresentation of material fact. The Plan must also state that coverage may not be contested 2 years after issuance of the Plan for any reason. • Rescission is a cancellation of coverage that has retroactive effect. It includes a cancellation that voids benefits paid. • Coverage may not be rescinded except with 30 days prior notice to each enrolled person who would be affected.	42 U.S.C. § 300gg-12 45 CFR §147.128 RI Gen Law §§ 27-18-8, 27-18-72, 27-19-6, 27-19-62, 27-20-6, 27-20-58, 27-41-29.2 OHIC/DBR Reg. 23 Part VIII, Section 1(2)	pp. 115-116, Ch. 8, §3.5	X	☐
Explanation:				
13. The Plan must cover preventive services without cost sharing requirements including deductibles, co-payments, and co-insurance. • Covered preventive services include: o Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the USPSTF; o Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (CDC); o Evidence-informed preventive care and screenings provided for in HRSA guidelines for infants, children, adolescents, and women; and o Current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention.	PHSA §2713 45 CFR §147.130 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2	pp viii-xiv - Summary of Benefits p. 44-46, Ch. 4, §2.1	X	☐
Explanation:				
14. The Plan must provide coverage for dependents up to age 26 if the Plan offers dependent coverage. • Eligible children are defined based on their relationship with the participant.	42 U.S.A. § 300gg-14 45 CFR §147.120	pp. 3-6, Ch. 1, §2.1 p. 8 Ch. 1, §2.3	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
• Limiting eligibility is prohibited based on: o financial dependency on primary subscriber, o residency, o student status, o employment, o eligibility for other coverage, o marital status. • Terms of the policy for dependent coverage cannot vary based on the age of a child.	RI Gen Law §§ 27-18-59, 27-19-50, 27-20-45, 27-41-61			
Explanation:				
15. The Plan must cover emergency services in accordance with the following: • No prior authorization. • No limitation to only services and care at participating providers. • Must cover at in-network cost-sharing level (patient is not penalized for emergency care at out-of-network provider). • Must pay for out-of-network emergency services the greatest of: (1) The median in-network rate; (2) the usual customary and reasonable rate (or similar rate determined using the plans or issuer's general formula for determining payments for out-of-network services); or (3) the Medicare rate.	42 U.S.C. § 300gg-19a(b) 45 CFR §147.138 RI Gen Law §§ 27-18-76, 27-19-66, 27-20-62, 27-41-79 SSA §1395dd	pp.26-28 , Ch. 3, §3.1 p. 81, Ch. 5, §1.1	X	☐
Explanation:				
16. For network plans requiring a primary care provider to be designated and requiring referrals: • The Plan must allow each enrollee to designate any participating primary care provider who is available to accept such individual. • The Plan must permit a physician specializing in pediatrics to	42 U.S.C. § 300gg-19a(a), (c), and (d) 45 CFR §147.138	pp. 20-22, Ch. 3, §2.1	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
• be designated as primary care provider. • The Plan must not require a referral for services to be provided by in-network OB/GYNs. The Plan must treat the ordering of OB/GYN items or services by an OB/GYN as it had been ordered or authorized by the primary care provider.	RI Gen Law §§ 27-18-44	pp. 22-23, Ch. 3, §2.2	X X X	☐ ☐ ☐
Explanation:				
17. In connection with maternity coverage, the Plan must provide coverage as follows: • Benefits may not be restricted to less than 48 hours following a vaginal delivery, and 96 hours following a cesarean section. This requirement does not apply if the provider, in consultation with the mother, decides to discharge the mother or the newborn prior to the minimum length of stay. • No prior authorization required for the minimum hospital stay. • For purposes of maternity coverage requirements, hospital length of stay begins at the time of delivery if delivery occurs in a hospital and at time of admission in connection with childbirth if delivery occurs outside the hospital. • No denial of mother/newborn eligibility, continued eligibility, to enroll or to renew coverage to avoid these requirements. • No monetary payments or rebates to encourage mothers to accept less than the minimum stay requirements. • No penalty for an attending provider who provides services in accordance with these requirements. • No incentives to an attending provider to induce the provider to provide care inconsistent with these requirements. • No restriction of benefits for any portion of a period within the minimum stay periods in a manner less favorable than the benefits provided for any preceding portion of such stay. • No requirement that the mother give birth in a hospital.	42 U.S.C. § 300gg-25 45 CFR §148.170 RI Gen Law §§ 27-18-33.1, 27-19-23.1, 27-20-17.1, 27-41-33.1, 27-41-43 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2	pp. 52-53, Ch. 4, §2.1	X X X	☐ ☐ ☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
No requirement that the mother to stay in the hospital for a fixed period of time following the birth of her child.				
Explanation:				
18. The Plan must state that it provides, and must provide coverage for parity in mental health and substance use disorder benefits ("Parity"), in accordance with the following: • Coverage for the medical treatment of mental illness and substance abuse must be provided under the same terms and conditions as that coverage is provided for other illnesses and diseases. • The Plan must describe, through illustrations, FAQ's, or other consumer explanation how the Plan provides for Parity in connection with financial requirements, quantitative treatment limitations, prescription drug benefits, and non-quantitative treatment limitations.	42 U.S.C. § 300gg-26 45 CFR §146.136 RI Gen Law § 27-38.2-1	pp. 53 + 55, Ch. 4, §2.1	X	☐
Explanation:				
19. The Plan must provide coverage for reconstructive surgery after mastectomy (Women's Health and Cancer Rights Act). The Plan must describe, through illustrations, FAQ's, or other consumer explanation how the Plan covers reconstructive surgery after mastectomy, including the scope of coverage, and cost-sharing consistent with other medical/surgical benefits.	PHSA §2727 RI Gen Law §§27-8-39, , 27-20-29, 27-41-43 OHIC Reg. 17	pp. 50-51, Ch. 4, §2.1	X	☐
Explanation:				
20. The Plan must state that coverage is guaranteed renewable, and that the Issuer may non-renew or cancel coverage under the Plan only for nonpayment of premiums, fraud, market exit, movement outside of service area, or cessation of bona-fide association membership.		p. 116, Ch. 8, §5.1	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
	RI Gen Law § 27-18.5-4			
Explanation:				
21. The Plan must state that it does not limit coverage based on genetic information. 22. The Plan must state that the Issuer will not: (i) adjust premiums based on genetic information; (ii) request /require genetic testing; (iii) or collect genetic information from an individual prior to, or in connection with enrollment in a plan, or at any time for underwriting purposes.	PHSA §2753 45 CFR §148.180 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2	p. 122, Ch. 9, §1.3	X X	☐ ☐
Explanation:				
23. The Plan must provide coverage for individuals participating in approved clinical trials. The Plan must describe, through illustrations, FAQ's, or other consumer explanation how the Plan provides such coverage, including the scope of coverage, individuals qualified, clinical trials that will be approved, and network provider limitations.	42 U.S.C. § 300gg-8 RI Gen Law §§ 27-18-74, 27-19-64, 27-20-60, 27-41-77	pp. 56-57, Ch. 4, §2.1	X	☐
Explanation:				
24. The Plan must state that the enrollee may terminate coverage upon no greater than 14 days notice to the Issuer or the Exchange. 25. For QHPs only, the Plan must state that the Issuer is permitted to terminate coverage if: • The enrollee is no longer eligible for coverage through the Exchange. • Payment of premiums cease (after appropriate grace periods	45 CFR § 155.430 45 CFR § 156.270(d) - (g) RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2 RI Gen Law § 27-18-3(a)(3);	p. 112, Ch. 8, §2.1 pp. 112-114, Ch. 8, §2.1	X X	☐ ☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
applied as described below); • The enrollee's coverage is rescinded for a non-prohibited reason. • The Qualified Health Plan is terminated or decertified. • The enrollee changes from one plan to another through during an open or special enrollment period.				
26. The Plan must state that if coverage is terminated, 30 days prior notice is required, and the notice must include the reason for termination.		p. 113, Ch. 8, §2.1	X	☐
27. The Plan must state that a 3 month grace period is provided for enrollees in a Qualified Health Plan who are recipients of advance payments of premium tax credit. The Issuer must provide the enrollee with notice of payment delinquency, unless the Exchange has accepted the obligation to do so on behalf of the Issuer.		p. 113, Ch. 8, §2.1	X	☐
28. For all other enrollees, the Plan must state that a 30 day grace period is provided.		p. 113, Ch. 8, §2.1	X	☐
Explanation:				
Claims, Internal Appeals, and External Appeals 29. The Plan must include a description of its claims procedures, procedures for obtaining prior approval, preauthorization procedures, utilization review procedures, adverse benefit determination procedures, internal appeals, external appeals, and the applicable time frames for these policies and procedures. Such policies and procedures must be in accordance with federal laws and regulations, in accordance with state laws and regulations that are not in conflict with such federal laws and regulations, and in accordance with the requirements of this checklist.	42 U.S.C. § 300gg-19 45 CFR § 147.136 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2 RI Gen Law §§ 23-17.12-1 et seq., 23-17-13-1 et seq. (where not in conflict with federal laws and regulations).	pp. 18 & 20, Ch. 3, §1.3 pp. 98-109, Ch. 7, §§1-6	X	☐
30. The Plan must include the standards, including the Plan's medical		pp.17 + 18, Ch. 3, §1.2 p. 133, Ch. 10	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
necessity standard, applicable to prior approval, preauthorization, and utilization review procedures. The Plan's definition of "medical necessity" must: • Require coverage of health care services that are appropriate, in terms of type, amount, frequency, level, setting, and duration to the member's diagnosis or condition. • Must be informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters.	DOH Regulations 23-17-12-UR and 23-17.13-CHP (where not in conflict with federal laws and regulations).			
31. The Plan must explain to the enrollee how to obtain the clinical review criteria used to determine medical necessity in a particular situation.		p. 108, Ch. 7, §5.2	X	☐
32. The Plan's definition of adverse benefit determination must be the definition used in 29 C.F.R. § 2560.530-1. The term also includes a rescission of coverage.		p. 103, Ch. 7, §4.1	X	☐
33. In connection with external appeals, the Plan must provide that: • The cost of an external appeal must be borne by the issuer. • The claimant must not be charged a filing fee greater than $25. • Restrictions on the minimum dollar amount of a claim are not allowed. • The decision of the Independent Review Organization is binding on the issuer.		pp. 107-109, Ch. 7, §5	X	☐
Explanation:				

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Issuer and Plan Compliance Attestation
Rates
Individual and Small Group Markets

Health Insurance Issuer name: NEIGHBORHOOD HEALTH PLAN OF RI

Health Insurance Plan name: EXCHANGE PRODUCT 2014 - INDIVIDUAL MARKET

SERFF form tracking number: NHRI- 128992321

I, T. Clark Phillip, am a duly authorized officer of the above-identified Health Insurance Issuer ("Issuer") of an individual health insurance plan, or of a small group health insurance plan. I do hereby attest that I am knowledgeable as to the current federal and state laws and regulations applicable to the above-identified Health Insurance Plan ("Plan"). To the best of my knowledge and belief, I hereby attest that the Plan is in compliance with such federal and state laws and regulations, and I furthermore hereby attest and swear under oath that, to the best of my knowledge and belief:

Rate Attestations

1. The Issuer is participating in good faith in OHIC's Affordability Standards, in accordance with OHIC Regulation 2, Section 9.
2. The Issuer is in compliance with the Hospital Contracting Terms required as conditions of the Issuer's rate approvals.
3. The Issuer is participating and in good standing with the risk adjustment program, and the reinsurance program, or if the filing is made before the commencement of such programs the Issuer agrees to participate in such programs.
4. The Issuer is, or if the filing is made before January 1, 2014 the Issuer agrees to be in compliance with federal and state rating and underwriting requirements, and with the prohibition on variability of rates by geographic area.
5. In connection with Qualified Health Plans only (in the case of Plans proposed to issued only outside the Exchange, the Issuer may indicate that responses to the following attestations are "not applicable"):
    a. The Issuer is, or if the filing is made before the commencement of such programs the Issuer agrees to be in compliance with requirements relating to the segregated accounting of premium allocations for abortion services.
    b. The Issuer is, or if the filing is made before the commencement of such programs the Issuer agrees to be in compliance with uniform Plan pricing requirements for Plans offered inside and outside the Exchange. Evidence of compliance is attached as Exhibit A (e.g. an actuarial memorandum demonstrating compliance with such pricing requirements).

c. The Issuer is in compliance with Exchange requirements with respect to the offering of associated gold or silver actuarial value plans. Evidence of compliance is attached as Exhibit B (e.g. a statement identifying the associated health insurance plan filed with SERFF).

d. The Issuer is, or if the filing is made before the commencement of such programs the Issuer agrees to be in compliance with federal plan rate year requirements.

The Issuer, and the Officer attesting on behalf of the Issuer, hereby acknowledge that: (i) the Office of the Health Insurance Commissioner has relied on this Attestation in reviewing this filing, and (ii) should it be determined that an approved filing is materially false, misleading, or incorrect in any manner, appropriate corrective and disciplinary action, as authorized by the Commissioner, may be taken against the Issuer and the Officer completing this Certification, including but not limited to referral to appropriate authorities for perjury proceedings. R.I. Gen. Laws § 42-14-16, and R.I. Gen. Laws § 42-14-11(c).

Subscribed and sworn to under oath this 4th day of April, 2013.

Signature of Officer attesting on behalf of the Issuer: T Clark Philip

Date of Signature: 4/04/13

Printed Name: T. CLARK PHILLIP

Title: CHIEF FINANCIAL OFFICER

Mailing Address: 299 Promenade St Providence, RI 02908

Direct Telephone Number: 401-459-6611

Email Address: Cphillip@nhpri.org

Michelle Tetreault

Notary Public

Carrier Name:
Plan Type(s):
Market Segment:
Rate Effective Date:

Plan Number
Totals
Totals *weighted by Total Members/Enrolled Policyholders + Covered Dependents*
Totals *weighted by Impacted Members/Enrolled Policyholders + Covered Dependents*

Base Rate for EHB Plan
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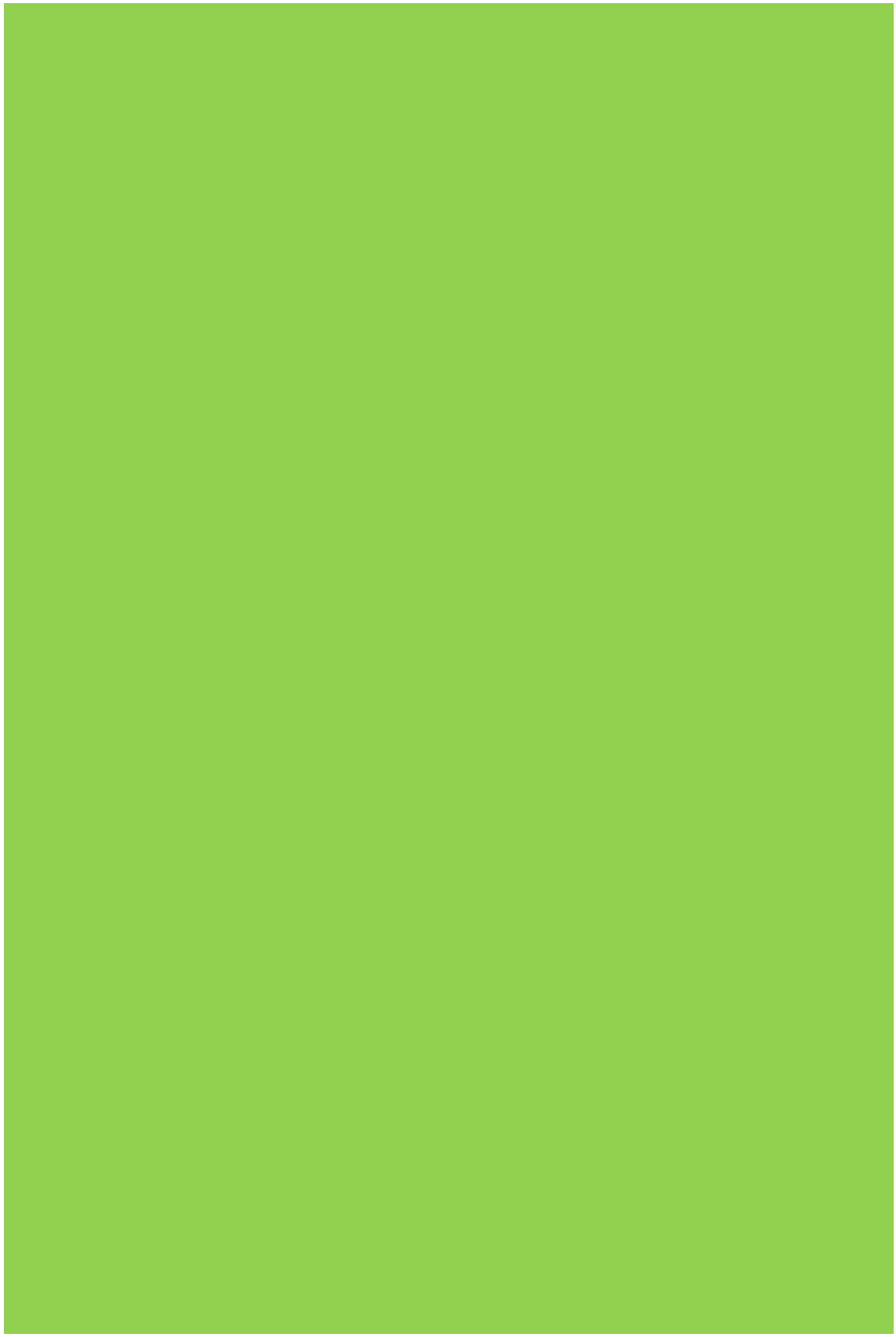
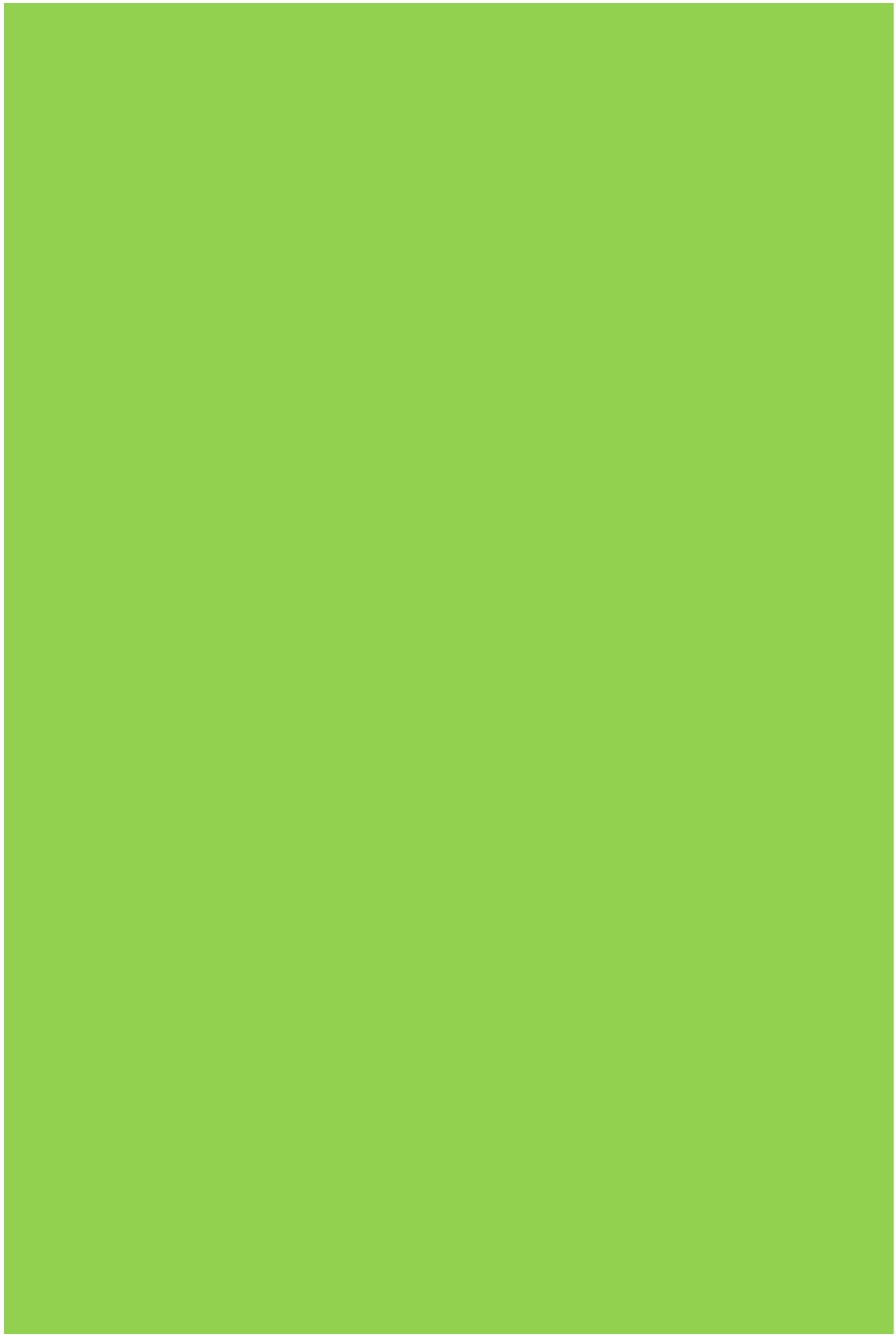
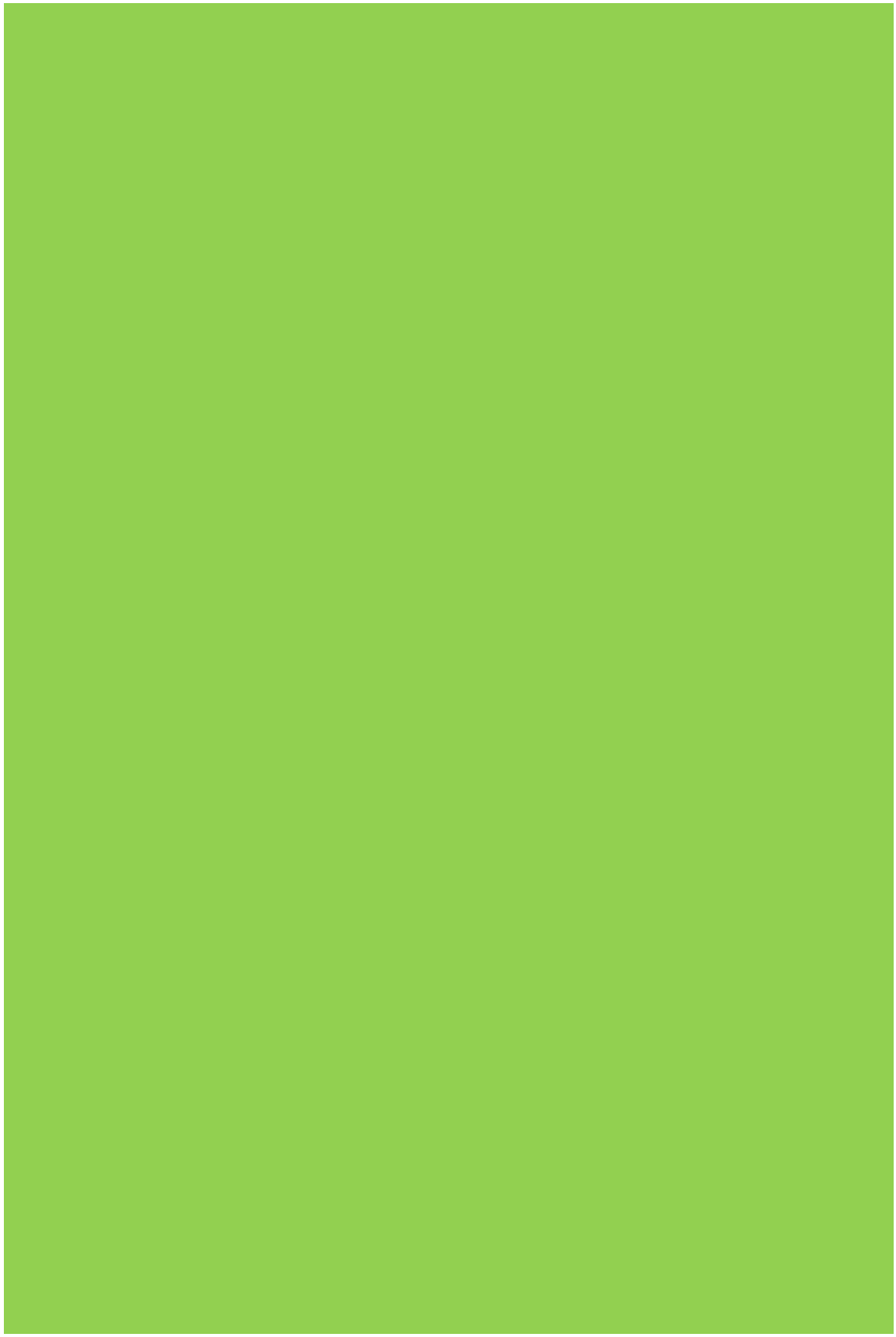
Plan 250

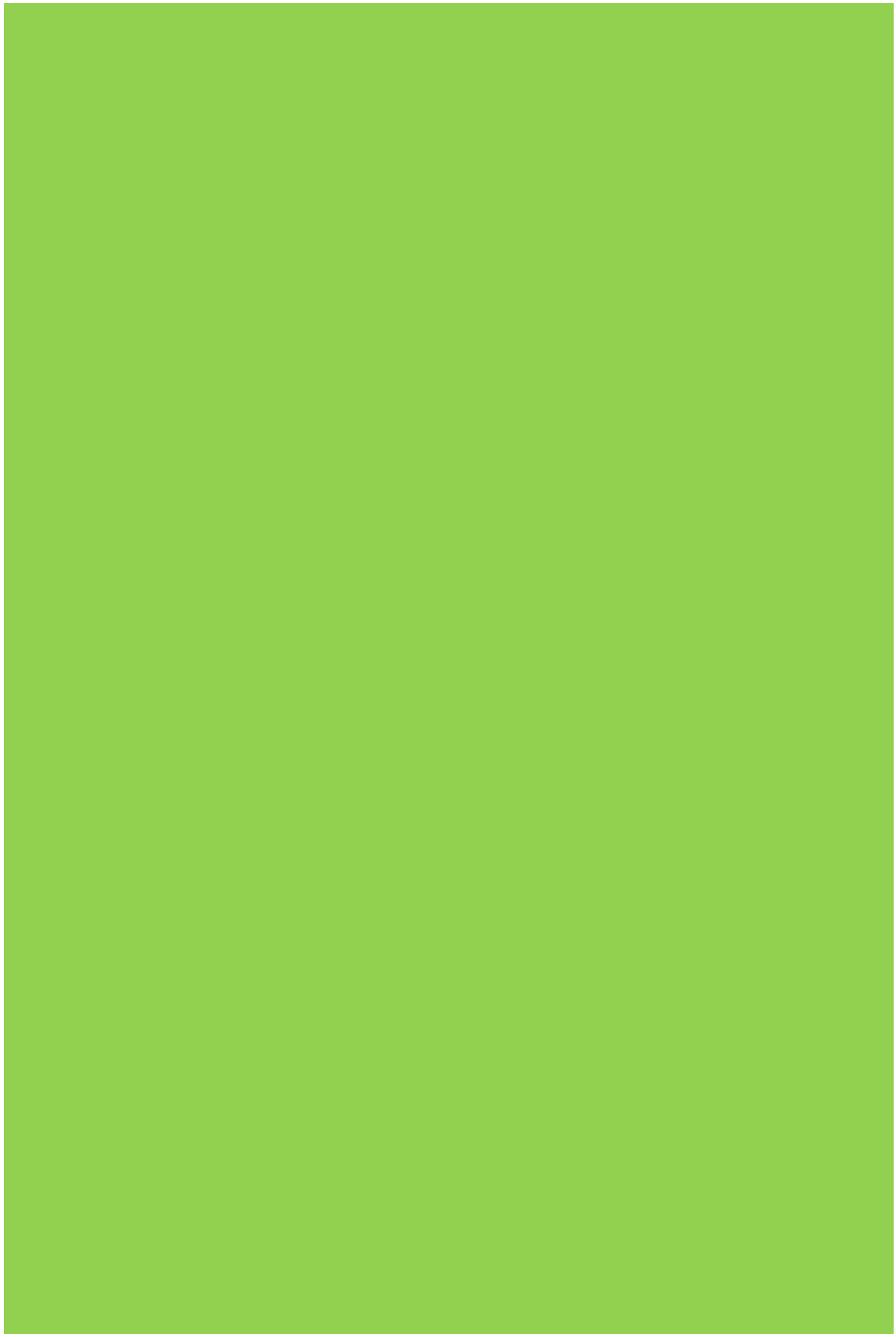
Neighborhood Health Plan of Rhode Island			
HMO		HMO/POS/PPO	
Individual		Small/Individual	
1/1/2014			

Plan Type (HMO, POS, PPO, Indemnity, Other)	**Pre-1/1/14 Carrier Plan Code or Name[4]**	**Discontinued, New, Existing (D, N, E)**	**1/1/14 Carrier Plan Code or Name[4]**
HMO		N	NHPRI Silver
HMO		N	NHPRI Gold









Notes:

1. The Members, Subscribers and Groups counts by health coverage plan should be based on the total me filed, regardless of renewal date.

2. The1/1/14 Members, Subscribers and Groups counts by health coverage plan should be based on the n

3. The Base Premium Rates should be normalized for rating factors. The intent is for OHIC to be able to ca as described in the rating formula.

4. The carrier should provide a plan name or code for each plan in column C. The carrier plan name or co index to change between rate filings.

5. The base rate PMPM should exclude the pediatric dental rider rate.

Rate Template Part III: Proposed Rate C

Metallic Tier	Metallic Tier Actuarial Value	Standard AV, Approach (1), Approach (2)	Exchange Y or N	Proposed Plan RelavityFactor for 1/1/14	Plan Relativity Factor for 1/1/13
Silver	70.2%	Standard AV	Y	0.75	
Gold	78.6%	Standard AV	Y	0.87	

embership in Rhode Island for the market segment (Individual or Small Group) and product(s) being

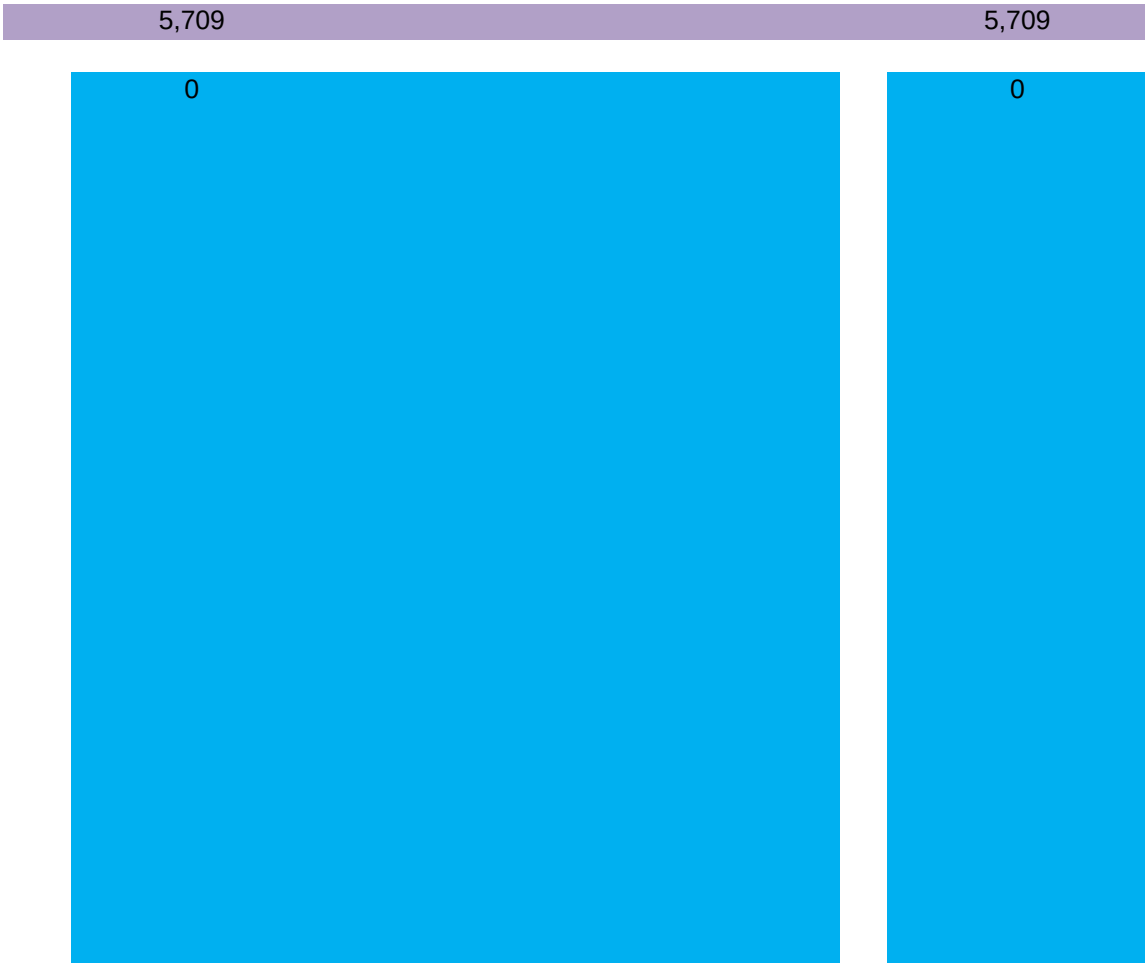
nembership renewing 1/1/14. This should be a subset of columns M-O

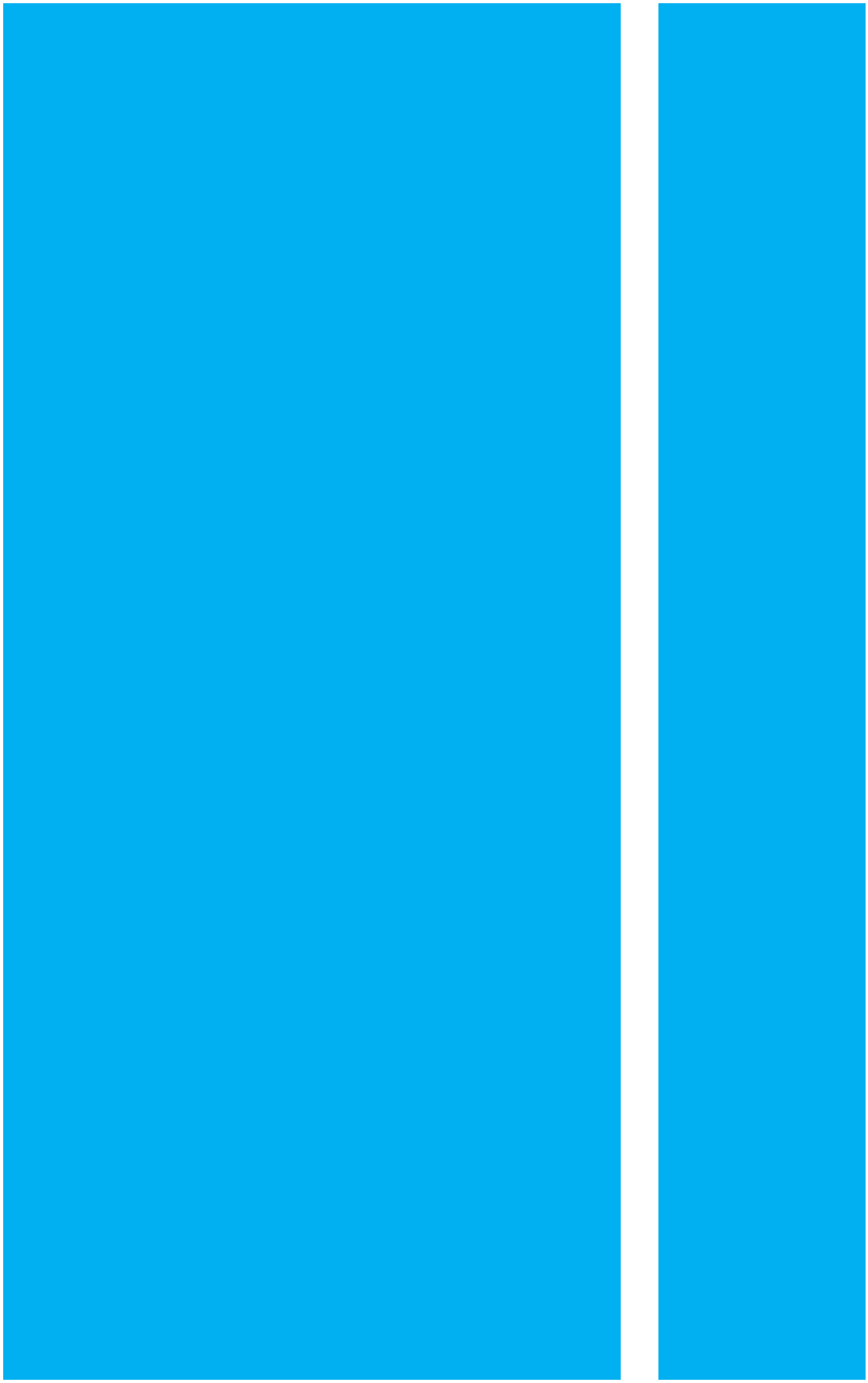
alculate final rates by utilizing the base rate PMPM's in this exhibit and all applicable rating factors,

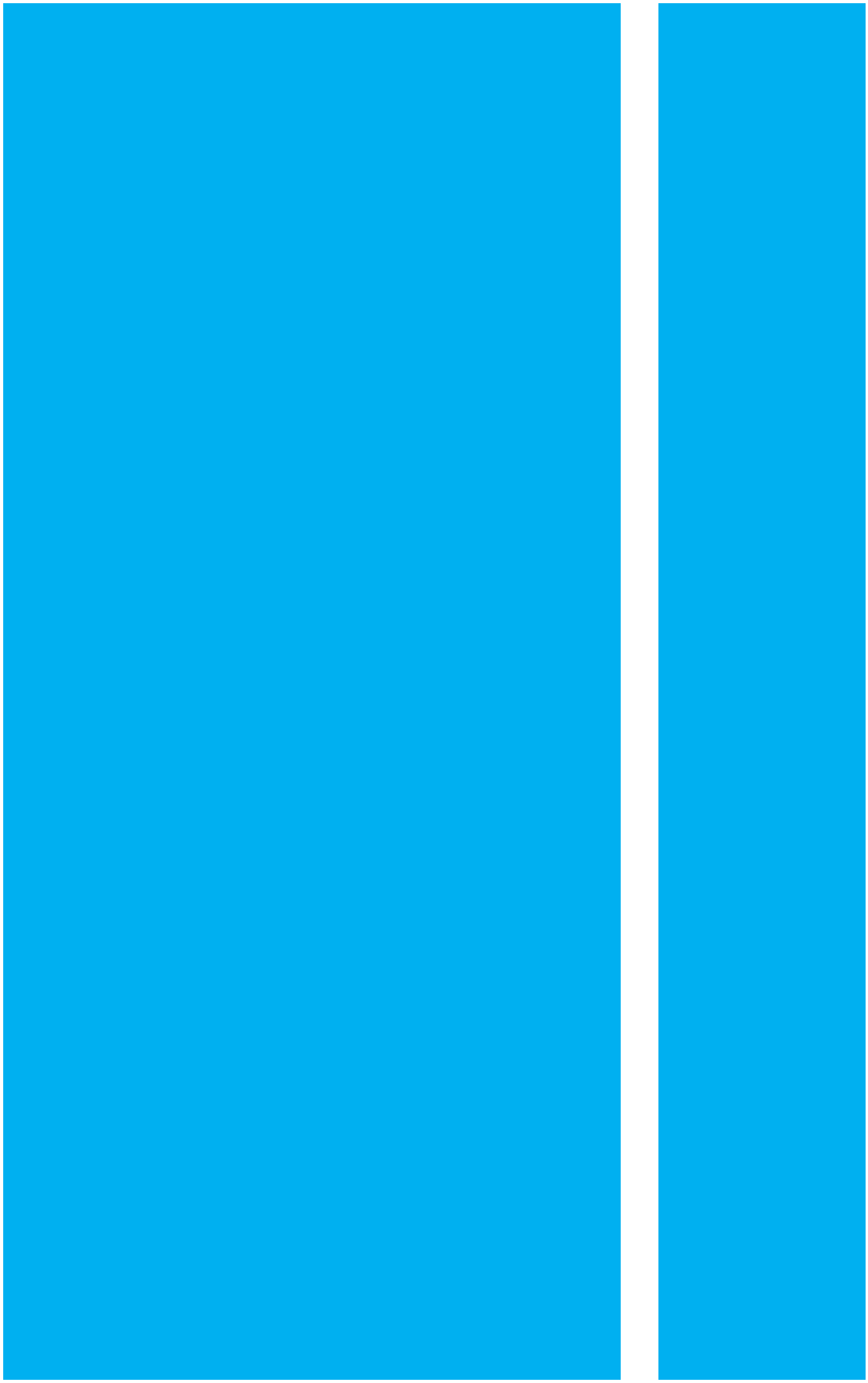
de in column C will correspond to an assigned plan index in column A. We do not expect this plan

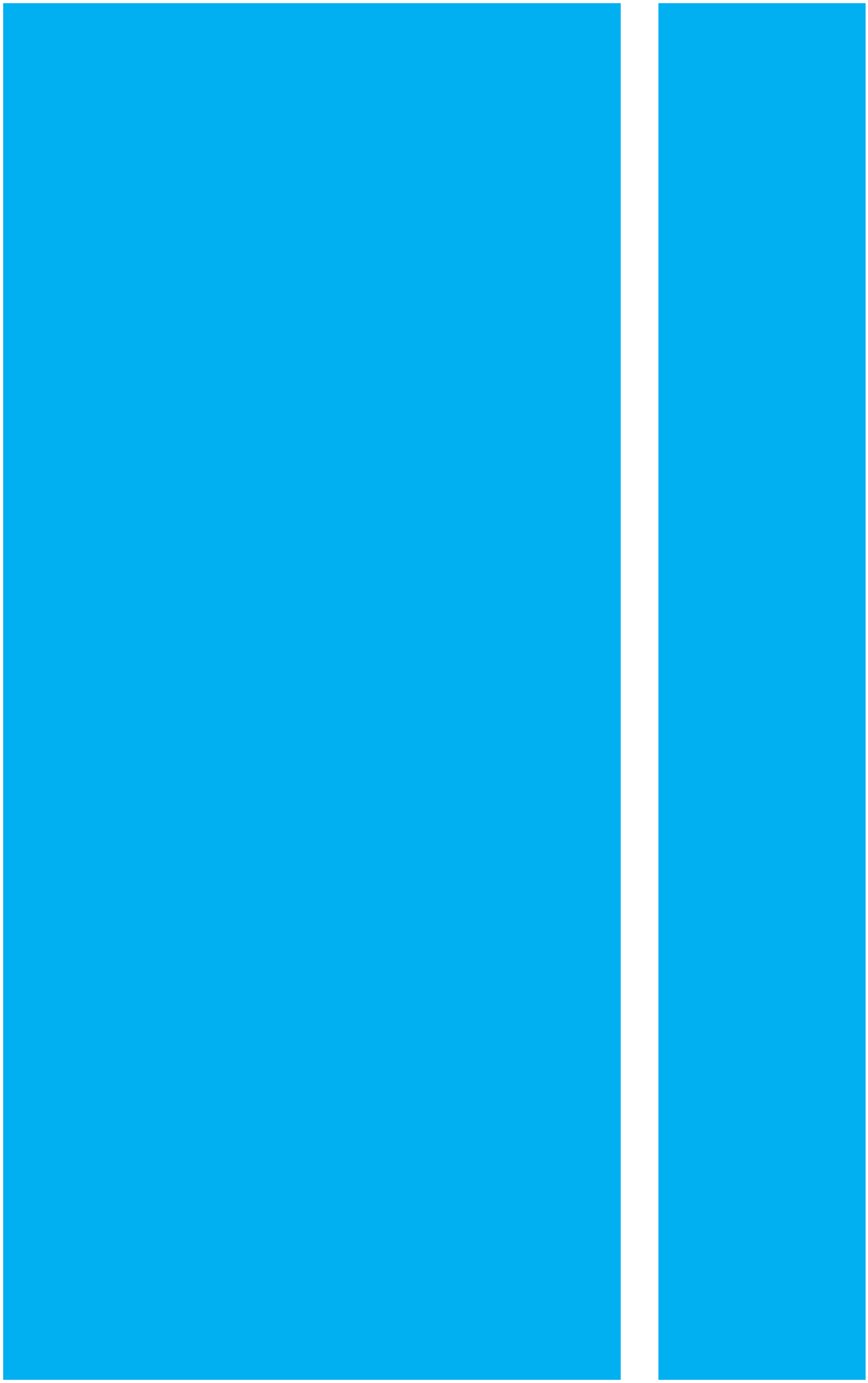
hange and Enrollment by Base Plan Rate PMPM

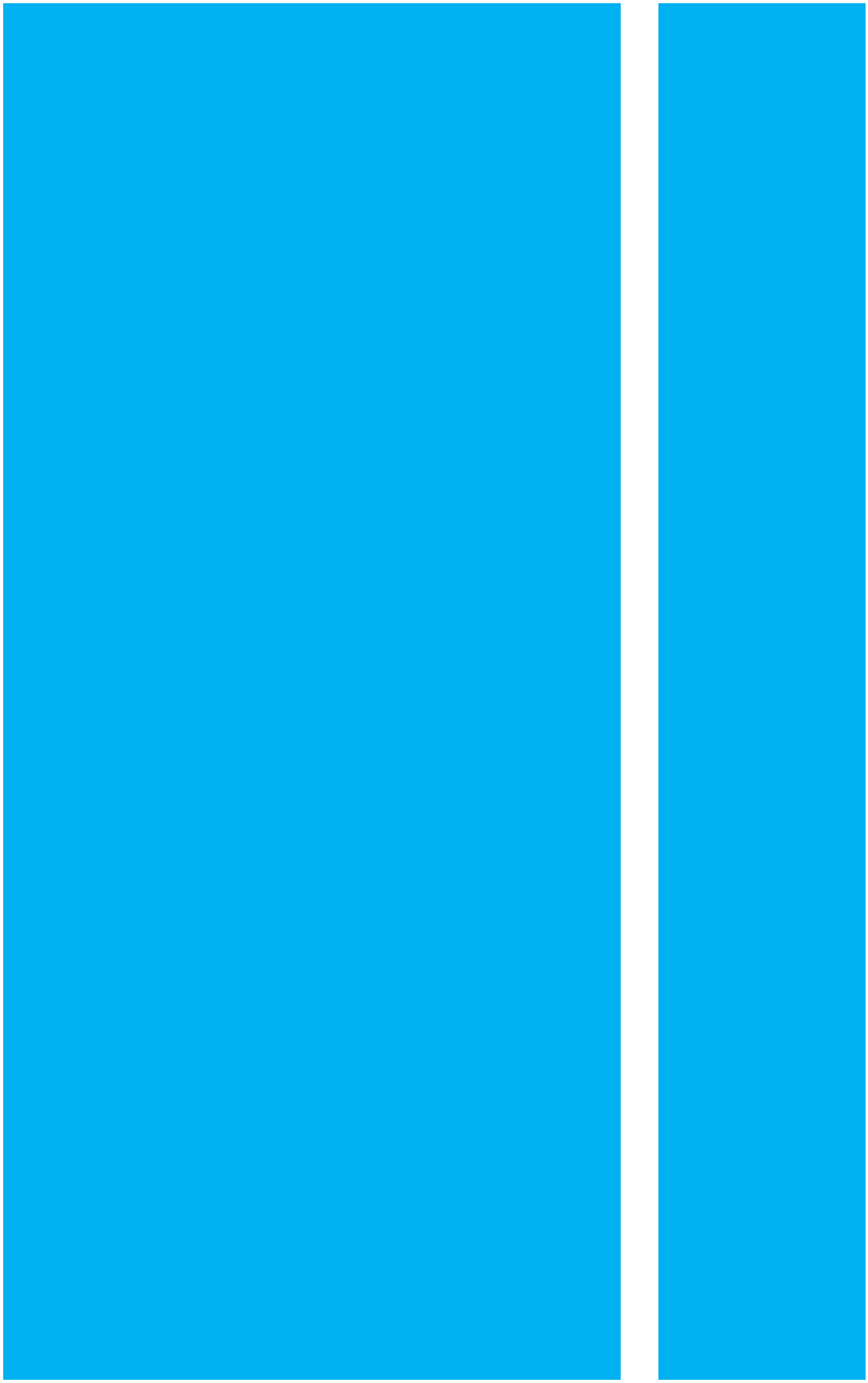
Total Number of Members/Enrolled Policyholders + Covered Dependents[1]	Total Number of Subscribers/Enrolled Policyholders[1]	Total Number of Groups[1]	1/1/14 Number of Members/Enrolled Policyholders + Covered Dependents[2]
5,709	**0**	**0**	**5,709**





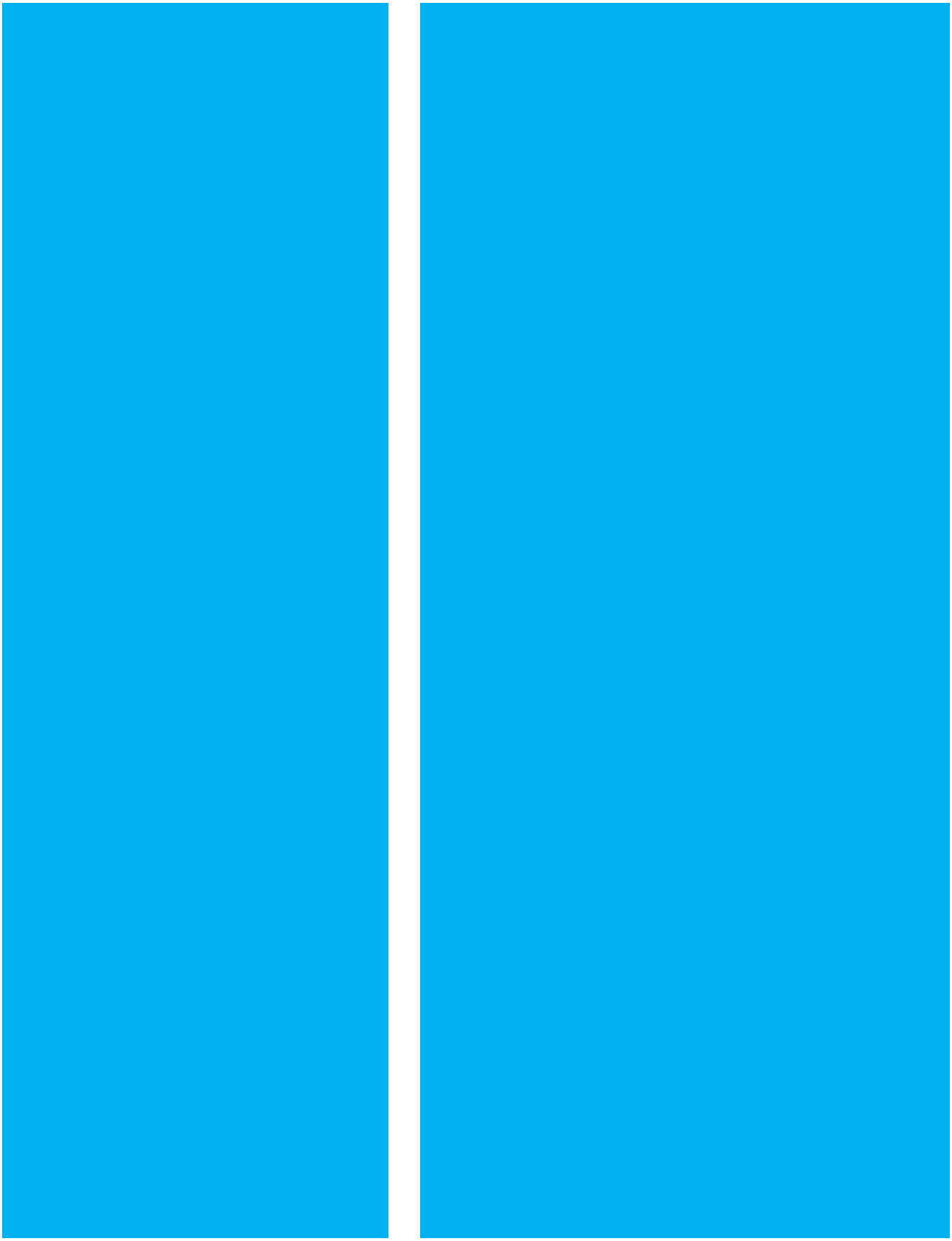


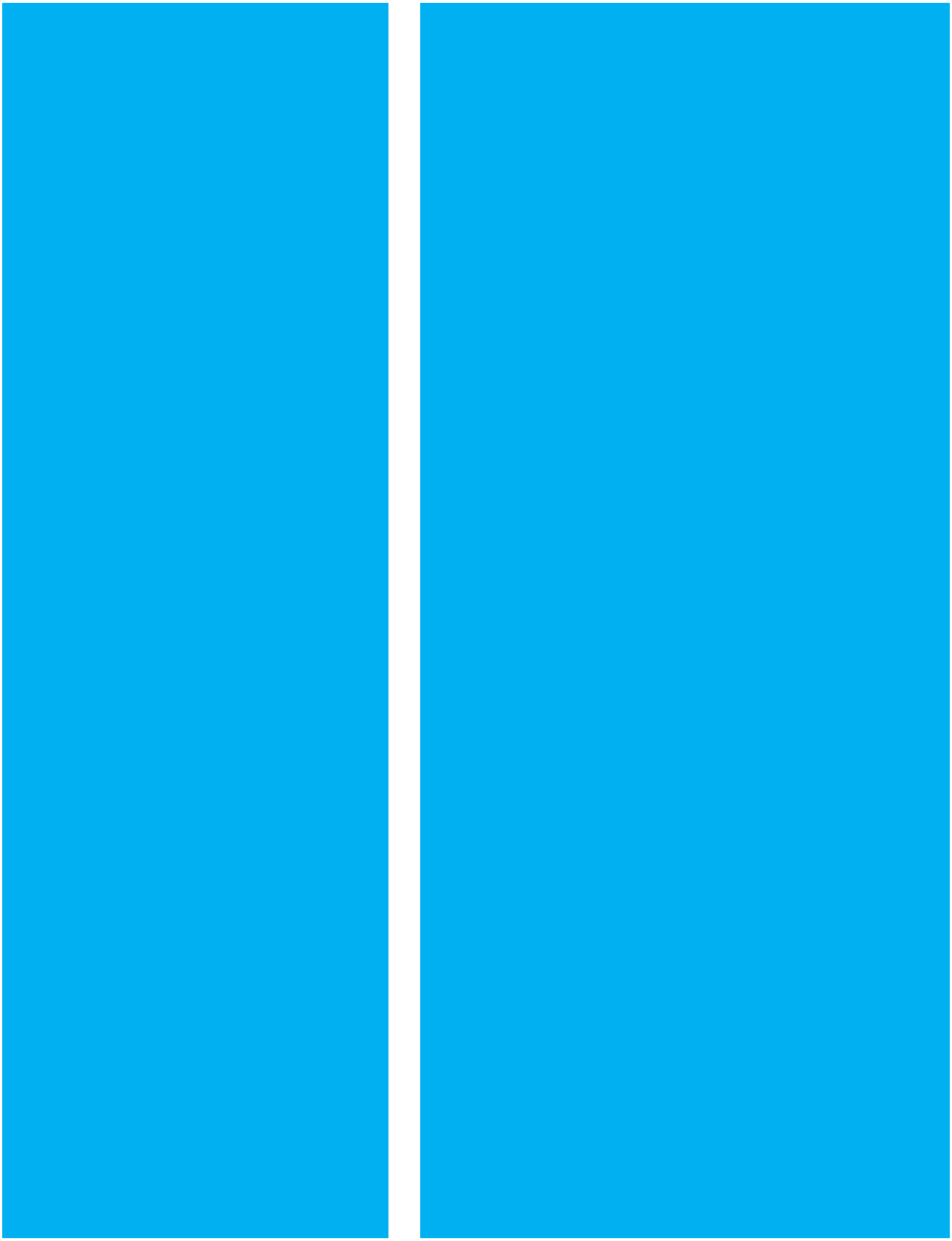


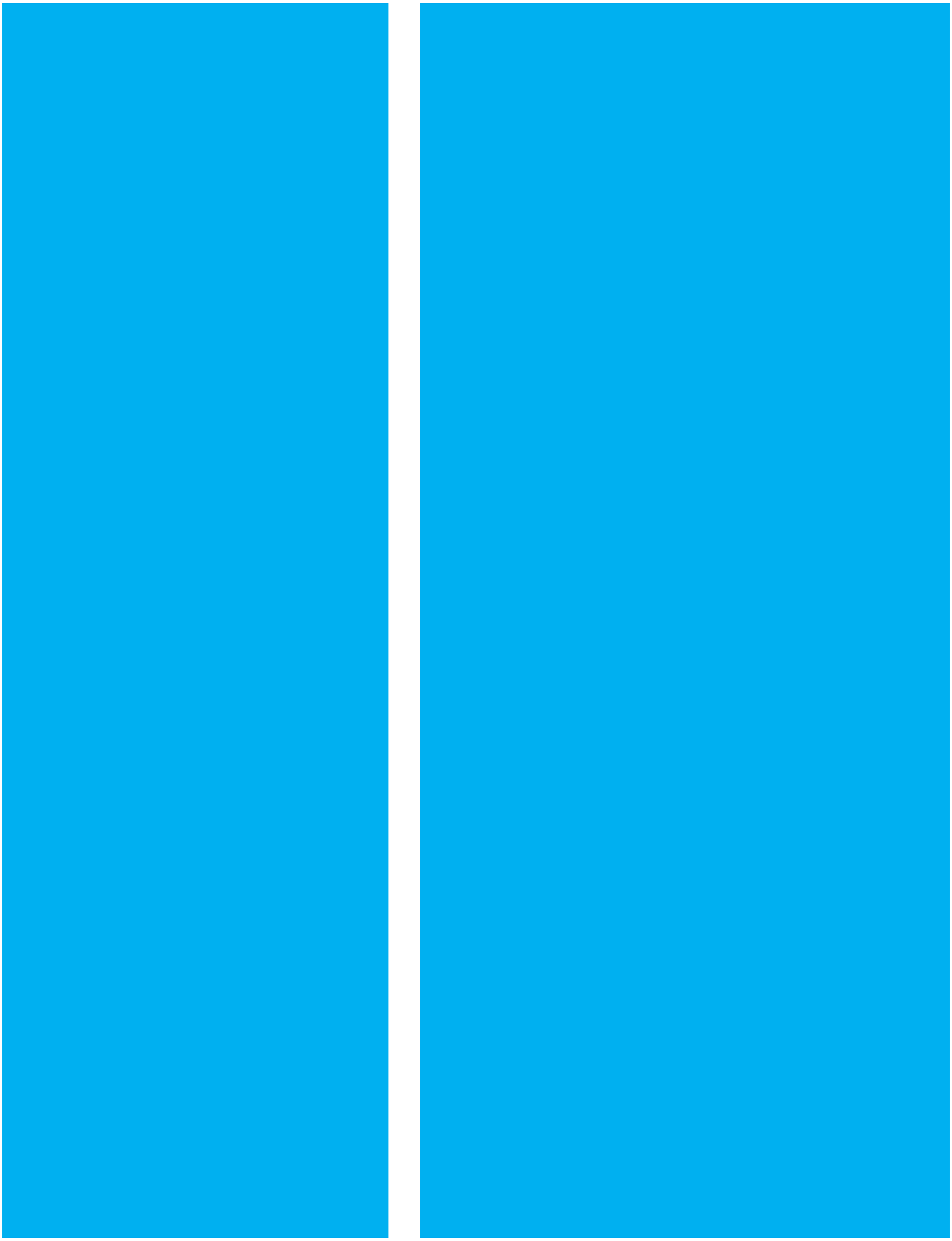


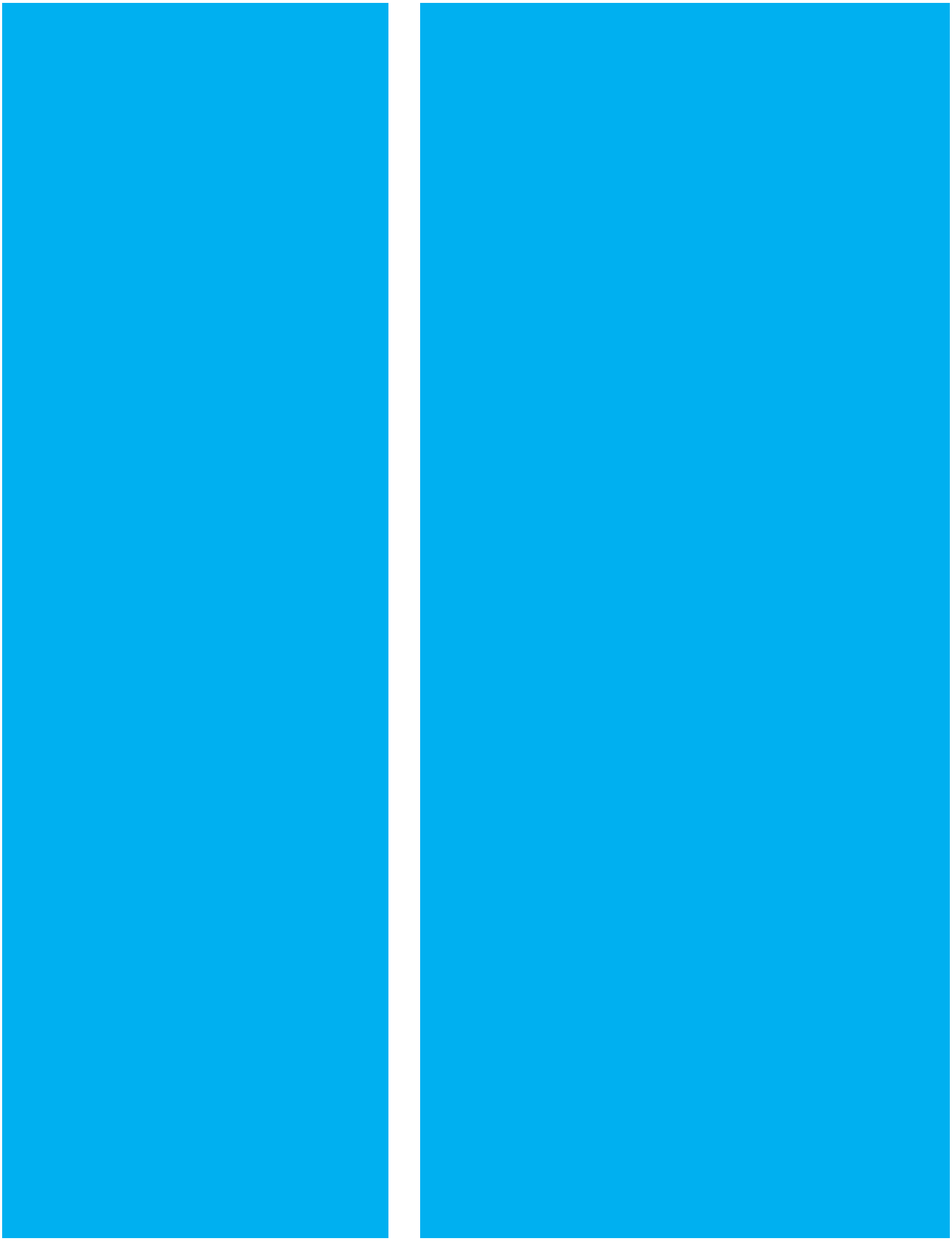
Rate Template Part III: Proposed Rat

1/1/14 Number of Subscribers/Enrolled Policyholders[2]	1/1/14 Number of Groups[2]	Base Plan Rate PMPM in effect 12 months Prior to Rate Effective Date[3]	Proposed Base Plan Rate PMPM for Rate Effective Date[3, 5]
0	0		
		$0.00	$345.99
		$0.00	$345.99
			$345.99
			$345.99









te Change and Enrollment by Base Plan Rate PMPM

Proposed Pediatric Dental Rate PMPM for Rate Effective Date[3]	Proposed Rate Change Compared to Prior 12 months	% of Total Members/Enrolled Policyholders + Covered Dependents	% of 1/1/14 Members/Enrolled Policyholders + Covered Dependents
	#DIV/0! **#DIV/0!**		
	#DIV/0!	100.0%	100.0%
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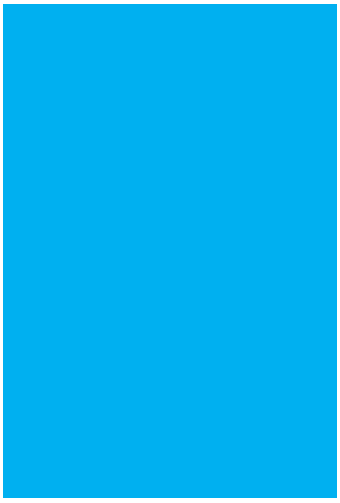

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NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND

Individual Market Products
Part II, Consumer Narrative Justification

Neighborhood Health Plan of Rhode Island's (Neighborhood) mission is to secure access to high quality, cost-effective health care for Rhode Island's at-risk populations. To accomplish this mission, Neighborhood offers low-cost health insurance coverage through Rhode Island programs such as RIte Care and Rhody Health Partners. Neighborhood's vision is for –everyone in Rhode Island to have comprehensive healthcare coverage and access to high-quality health care. In service of this vision, beginning in 2014, we are pleased to be able to offer health insurance products to individuals residing in Rhode Island through the Rhode Island Health Benefit Exchange (RIHBE).

Milliman, Inc. (Milliman) was retained by Neighborhood to prepare the premium rates for Individual market products to be offered on the RIHBE. Neighborhood has not offered products in the commercial health insurance market prior to 2014, experience data was not available for developing premium rates. Because of this, the premium rates and rating factors for these products were developed from information published in the ***Milliman Health Cost Guidelines™*** and from information provided by Neighborhood.

Neighborhood is sensitive to healthcare affordability concerns. We believe that the premium rates being proposed for these plans are appropriate in relation to the benefits and provisions offered. Administrative expenses, including contributions to surplus, taxes and fees will represent approximately 20% of premium. The projected credibility adjusted loss ratio for these new products is 91.0%, which is well above the federal minimum loss ratio.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis.

Neighborhood looks forward to expanding upon its mission, and working with the state to toward delivering affordable health care for all Rhode Islanders.

Individual

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☑
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$5,400.00	$500.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)						
OOP Maximum if Separate ($)	$5,400.00	$1,000.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$0.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$0.00	☑	☑		
Specialist Visit	☑	☐		$0.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$0.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$0.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$40.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$60.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$60.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	60.7%
Metal Tier:	Bronze

Individual

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☑
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)	$3,000.00	$250.00	
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%	
OOP Maximum ($)			
OOP Maximum if Separate ($)	$5,000.00	$1,000.00	

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$25.00	☑	☑		
Specialist Visit	☐	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$25.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑		$0.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☑		$0.00	☑	☑		
Skilled Nursing Facility	☑	☑		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$40.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$60.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$60.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.2%
Metal Tier:	Silver

Individual

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☑
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,000.00	$250.00				
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%				
OOP Maximum ($)						
OOP Maximum if Separate ($)	$4,000.00	$750.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$25.00	☑	☑		
Specialist Visit	☐	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$25.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑		$0.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☑		$0.00	☑	☑		
Skilled Nursing Facility	☑	☑		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$40.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$60.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$60.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.9%
Metal Tier:	Silver

Individual

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☑
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,000.00	$50.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%				
OOP Maximum ($)						
OOP Maximum if Separate ($)	$2,000.00	$250.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$25.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$5.00	☑	☑		
Specialist Visit	☐	☐		$10.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$5.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑		$0.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$10.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$10.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☑		$0.00	☑	☑		
Skilled Nursing Facility	☑	☑		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$2.00	☑	☑		
Preferred Brand Drugs	☑	☐		$4.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$6.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$6.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.3%
Metal Tier:	Platinum

Individual

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☑
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$250.00	$10.00				
Coinsurance (%, Insurer's Cost Share)	90.00%	100.00%				
OOP Maximum ($)						
OOP Maximum if Separate ($)	$750.00	$100.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$25.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$5.00	☑	☑		
Specialist Visit	☐	☐		$10.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$5.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑		$0.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$10.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$10.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☑		$0.00	☑	☑		
Skilled Nursing Facility	☑	☑		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$2.00	☑	☑		
Preferred Brand Drugs	☑	☐		$4.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$6.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$6.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	94.1%
Metal Tier:	Platinum

Individual

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☑
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$100.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%				
OOP Maximum ($)						
OOP Maximum if Separate ($)	$4,000.00	$500.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$20.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$10.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑		$0.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$20.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$20.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☑		$0.00	☑	☑		
Skilled Nursing Facility	☑	☑		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$5.00	☑	☑		
Preferred Brand Drugs	☑	☐		$20.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$40.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$40.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.6%
Metal Tier:	Gold

Small Group

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☑
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%				
OOP Maximum ($)						
OOP Maximum if Separate ($)	$5,000.00	$1,000.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$0.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$0.00	☑	☑		
Specialist Visit	☑	☑		$0.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☑		$0.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑		$0.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☑		$0.00	☑	☑		
Skilled Nursing Facility	☑	☑		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$40.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$60.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$60.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.2%
Metal Tier:	Silver

Small Group

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☑
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%				
OOP Maximum ($)						
OOP Maximum if Separate ($)	$4,000.00	$500.00				

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$20.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$10.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑		$0.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$20.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$20.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☑		$0.00	☑	☑		
Skilled Nursing Facility	☑	☑		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$5.00	☑	☑		
Preferred Brand Drugs	☐	☐		$20.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$40.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$40.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.3%
Metal Tier:	Gold

LIMITATIONS

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and Neighborhood Health Plan of Rhode Island dated August 19, 2005.

This document has been prepared solely for the internal business use of, and is only to be relied upon by, the management of Neighborhood Health Plan of Rhode Island (Neighborhood). No portion of this report may be provided to any other party without Milliman's prior written consent. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work.

The analysis included in this report is based on our understanding of the ACA and its associated regulations to date. Forthcoming ACA-related regulations and additional legislation may materially change the impact of the ACA, necessitating an update to the analysis included in this report. For this reason, this report should be considered time-sensitive material which may change as new information becomes available.

QUALIFICATIONS

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Jeremy Palmer is a member of the American Academy of Actuaries, and meets the qualification standards for performing the analyses in this report.

Formulary—Inadequate Category/ Class Count Supporting Documentation and Justification

Please fill in the following information.

HIOS Issuer ID: 77514

Drug List ID(s)	Category	Class	Justification*
1	THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	Couldn't find more valid Rxcui's to add
1	ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	Couldn't find more valid Rxcui's to add
1	DERMATOLOGICAL AGENTS	NO USP CLASS	Couldn't find more valid Rxcui's to add
1	OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	Couldn't find more valid Rxcui's to add
1	ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	Couldn't find more valid Rxcui's to add
1	ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID ANTAGONISTS	Couldn't find more valid Rxcui's to add
1	ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	Couldn't find more valid Rxcui's to add
1	ANTIPARASITICS	ANTHELMINTICS	Couldn't find more valid Rxcui's to add
1	CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	Couldn't find more valid Rxcui's to add
1	GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	Couldn't find more valid Rxcui's to add

* Choose the appropriate letter in the Justification column or use free text to describe an "other" justification.

A = Drugs in this category and class have been discontinued by the manufacturer.

B = Drugs in this category or class have been deemed unsafe by the FDA or removed from market by the manufacturer due to safety concerns.

C = Drugs in this category and class have a DESI classification.

D = Drugs in this category or class have become available as generics during or after December 2012.

Formulary—Inadequate Category/ Class Count Supporting Documentation and Justification

Please fill in the following information.

HIOS Issuer ID: 77514

Drug List ID(s)	Category	Class	Justification*
1	GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	Couldn't find more valid Rxcui's to add
1	OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	Couldn't find more valid Rxcui's to add
1	OTIC AGENTS	NO USP CLASS	Couldn't find more valid Rxcui's to add

* Choose the appropriate letter in the Justification column or use free text to describe an "other" justification.

A = Drugs in this category and class have been discontinued by the manufacturer.

B = Drugs in this category or class have been deemed unsafe by the FDA or removed from market by the manufacturer due to safety concerns.

C = Drugs in this category and class have a DESI classification.

D = Drugs in this category or class have become available as generics during or after December 2012.

Rhode Island Individual, Small and Large Group Rate Filing Template Part I

Part 1. Historical Information

Experience Period for Developing Rates	
From	To

Utilization/Experience Data by Quarter (Experience Period only)

A. Incurred Data

Quarter	End Date	IP Days	Member Months	Earned Premium	Incurred Claims Total	Incurred Claims IP	Incurred Claims OP	Incurred Claims Primary Care	Incurred Claims Other M/S	Incurred Claims Rx	Capitation	Claims not Otherwise categorized (explain)	Loss Ratio	Quality Improvement Expense*	Other Cost Containment Expense*	Other Claim Adjustment Expense*	Other Operating Expense*	Investment Income Credit	Commissions	Contribution to Reserves
1 (Oldest)																				
2																				
3																				
4																				
5																				
6																				
7																				
8																				

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3- Analysis of Expenses and/or to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1

B. Allowed Data

Quarter	End Date				Allowed Claims Total	Allowed Claims IP	Allowed Claims OP	Allowed Claims Primary Care	Allowed Claims Other M/S	Allowed Claims Rx	Capitation	Claims not Otherwise categorized (explain)								
1 (Oldest)																				
2																				
3																				
4																				
5																				
6																				
7																				
8																				

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3- Analysis of Expenses and/or to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1

Part 2. Prospective Information

A. Trend Factors for Projection Purposes (Annualized)

	IP	OP	Primary Care	Other M/S	Rx	Capitation	Claims not Categorized	Weighted Total
Total								
Price Only								
Utilization								
Other**								
Other**								
Other**								
Weights								100%

** All elements should add or compound to the total. If anything is to be reported as "Other" please provide a description.

B. The following items for the period to which the rate filing applies, by quarter:

Quarter	Beginning Date	Average % Rate Increase	Expected Pure Medical Cost Ratio	Expected Contribution to Reserves %	Quality Improvement Expense %*	Other Cost Containment Expense %*	Other Claim Adjustment Expense %*	Other Operating Expense %*	Average Commissions %*	Investment Income Credit %*	Premium Tax %
1	1/1/2014		93.2%	3.0%	1.9%	2.9%	1.4%	8.6%	0.0%	0.0%	2.0%
2	4/1/2014		93.2%	3.0%	1.9%	2.9%	1.4%	8.6%	0.0%	0.0%	2.0%
3	7/1/2014		93.2%	3.0%	1.9%	2.9%	1.4%	8.6%	0.0%	0.0%	2.0%
4	10/1/2014		93.2%	3.0%	1.9%	2.9%	1.4%	8.6%	0.0%	0.0%	2.0%
Weighted Average			93.2%	3.0%	1.9%	2.9%	1.4%	8.6%	0.0%	0.0%	2.0%

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3 - Analysis of Expenses and to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1
The sum of the expenses, commissions, contributions to reserves, investment income credit, taxes and the medical loss ratio should be 100%.

C. Average Rate Increase Components

The following items should reconcile to the Weighted Average Percent Rate Increase for the year:

	Price	Utilization, Mix	Total
Hospital Inpatient Price			
Hospital Outpatient			
Primary Care			
Med/Surg Other Than Primary Care			
Pharmacy			
Administrative Expense (Aggregated)			
Contribution to Reserves			
Taxes and Assessments			
Legally Mandated Changes			
Prior Period Adjustment (+/-)			
Total			

Rate Template Part II

Company Legal Name:	**Neighborhood Health Plan**	State:	**RI**
HIOS Issuer ID:	**77514**	Market:	**Individual**
Effective Date:	**1/1/2014**		

Market Level Calculations (Same for all Plans)

Section I:

Experience Period: to 1/0/1900

	pmpm	% of Prem
Premiums (net of MLR Rebate) in Experience Period:		
Tax credits used to pay premiums in above		
Incurred Claims in Experience Period		
Allowed Claims:		
Experience Period Paid to Allowed Factor		
Index Rate of Experience Period		
Experience Period Member Months		

Section II: Allowed Claims, PMPM basis

Projection Period: 1/1/2014 to 12/31/2014 Mid-point to Mid-point, Experience to Projection: 1394 months

	Experience Period on Actual Experience Allowed				Adj't. from Experience to Projection Period		Annualized Trend Factors		Projections, before credibility Adjustment			Credibility Manual			After Credibility
Benefit Category	**Utilization Description**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Pop'l risk Morbidity**	**Other**	**Cost**	**Util & Other**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	
Inpatient Hospital				$ -	1.000	1.000	1.000	1.000	-	$ -	$ -	458.9	$ 2,812.97	$ 107.57	
Outpatient Hospital				-	1.000	1.000	1.000	1.000	-	-	-	3,259.8	521.26	141.60	
Primary Care				-	1.000	1.000	1.000	1.000	-	-	-	18,411.4	87.06	133.57	
Other Medical/Surgical				-	1.000	1.000	1.000	1.000	-	-	-	555.8	251.96	11.67	
Prescription Drug				-	1.000	1.000	1.000	1.000	-	$ -	$ -	17,941.0	$ 58.35	87.25	
Capitation					1.000	1.000	1.000	1.000	-	-	-	-	-	-	
Other Not Categorized					1.000	1.000	1.000	1.000	-	-	-	-	-	-	
Total				$ -							$ -	40,626.8		$ 481.65	

				Projected Period Total
Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)		0%	100%	$ 481.65	
Paid to Allowed Average Factor in Projection Period				0.748	
Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM				$ 360.11	$ 24,671,648
Projected Risk Adjustments in excess (less than) Experience Period, PMPM				11.06	757,589
Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM				$ 349.05	$ 23,914,058
Projected ACA reinsurance recoveries, net of rein prem, PMPM				34.02	2,330,836
Projected Incurred Claims				$ 315.03	$ 21,583,222
Administrative Expense Load			13.49%	52.16	3,573,444
Premium Tax			2.00%	7.73	529,614
Contribution to Reserves			3.00%	11.60	794,421
Single Risk Pool Gross Premium Avg. Rate, PMPM				386.52	$ 26,480,701
Index Rate for Projection Period				$481.65	
% increase over Experience Period				#DIV/0!	
% Increase, annualized:				#DIV/0!	
Base EHB Rate for Projection Period				$345.99	
Projected Member Months					68,511

Monthly Effective Date Projection Factor for each subsequent rate month (group only)	1.00000
1/1/2014	1.00000
2/1/2014	1.00000
3/1/2014	1.00000
4/1/2014	1.00000
5/1/2014	1.00000
6/1/2014	1.00000
7/1/2014	1.00000
8/1/2014	1.00000
9/1/2014	1.00000
10/1/2014	1.00000
11/1/2014	1.00000
12/1/2014	1.00000

Carrier Name:
Plan Type(s):
Market Segment:
Rate Effective Date:

Plan Number
Totals
Totals *weighted by Total Members/Enrolled Policyholders + Covered Dependents*
Totals *weighted by Impacted Members/Enrolled Policyholders + Covered Dependents*

Base Rate for EHB Plan
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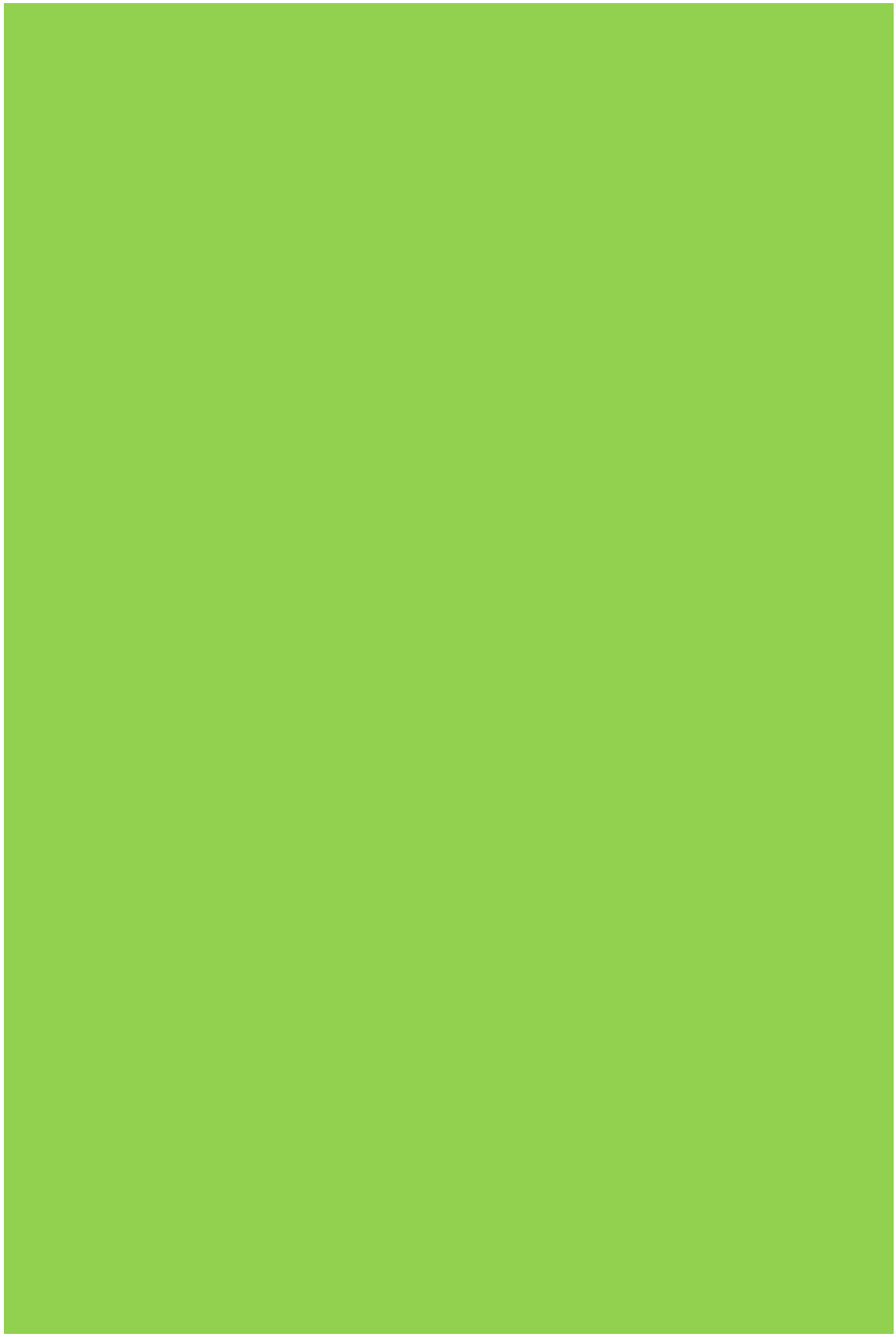
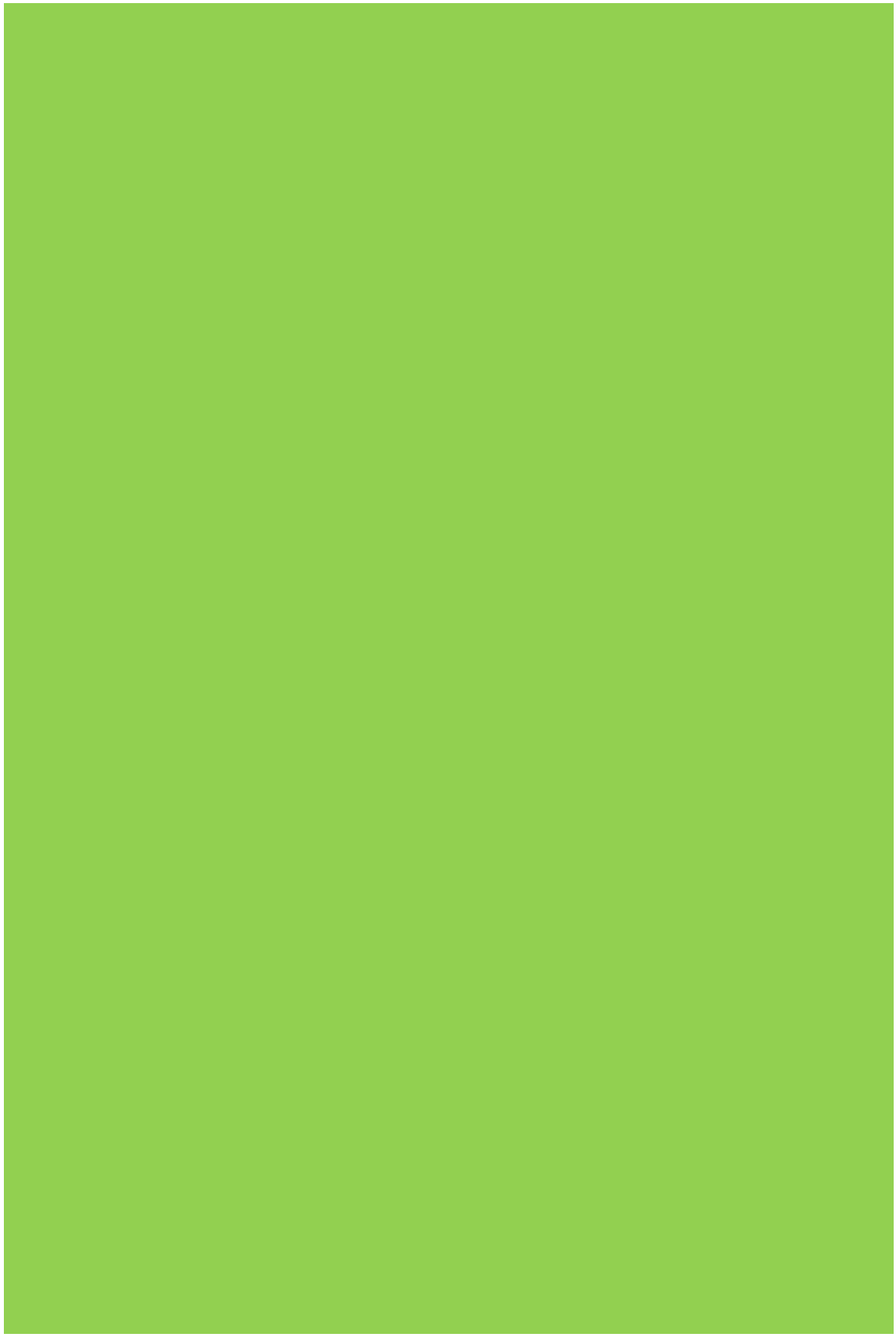
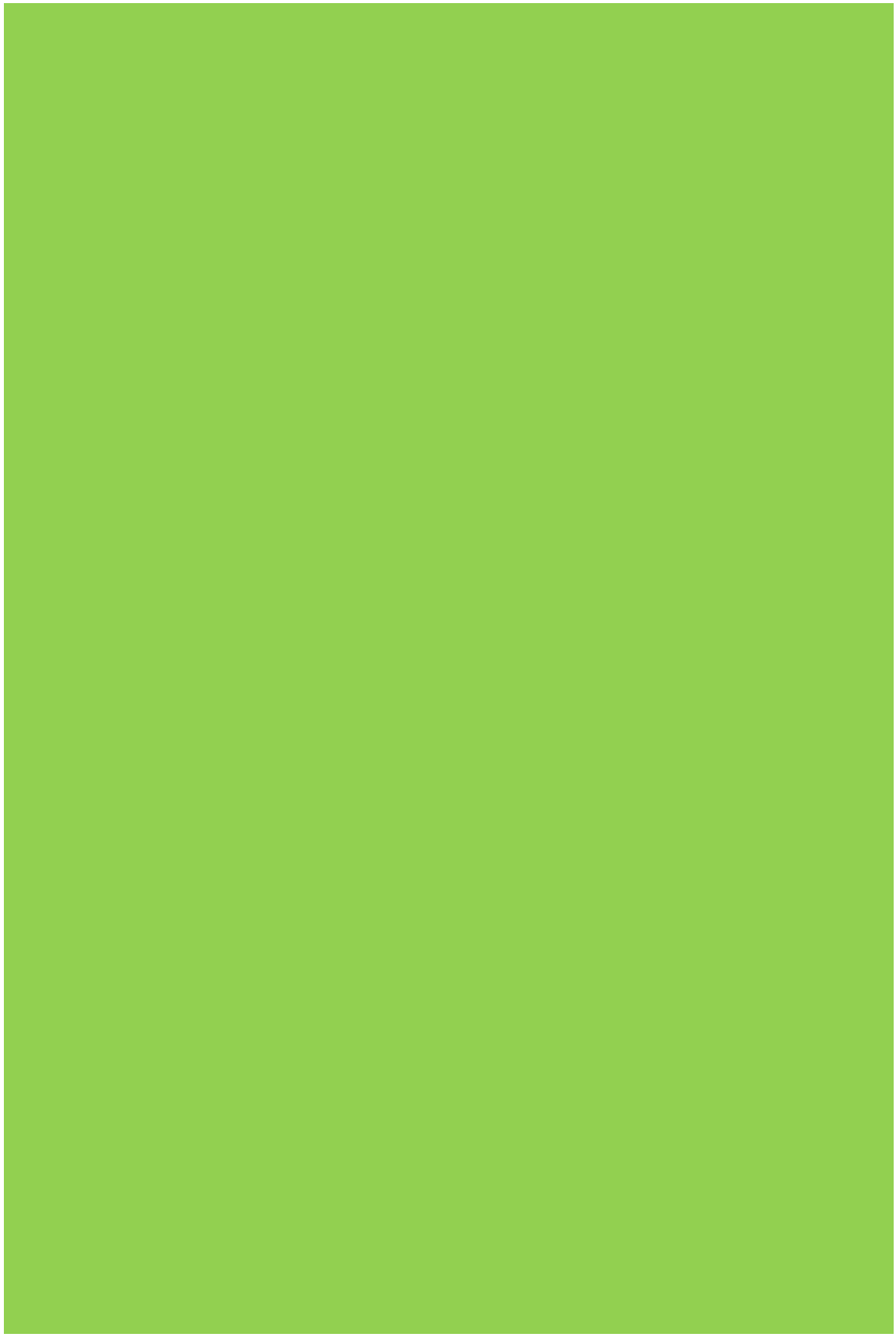
Plan 250

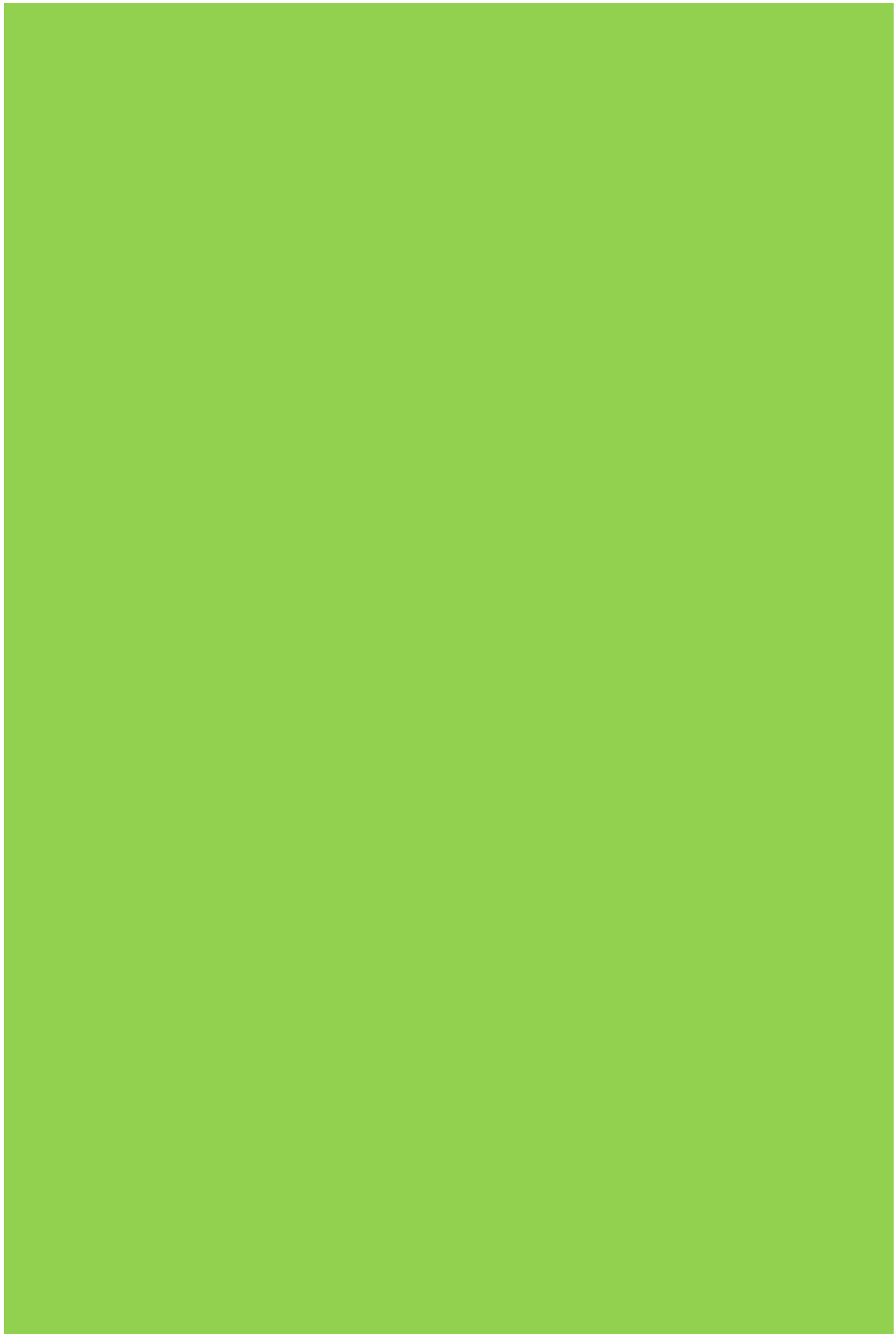
Neighborhood Health Plan of Rhode Island			
HMO		HMO/POS/PPO	
Individual		Small/Individual	
1/1/2014			

Plan Type (HMO, POS, PPO, Indemnity, Other)	**Pre-1/1/14 Carrier Plan Code or Name[4]**	**Discontinued, New, Existing (D, N, E)**	**1/1/14 Carrier Plan Code or Name[4]**
HMO		N	NHPRI Silver
HMO		N	NHPRI Gold









Notes:

1. The Members, Subscribers and Groups counts by health coverage plan should be based on the total me filed, regardless of renewal date.

2. The1/1/14 Members, Subscribers and Groups counts by health coverage plan should be based on the n

3. The Base Premium Rates should be normalized for rating factors. The intent is for OHIC to be able to ca as described in the rating formula.

4. The carrier should provide a plan name or code for each plan in column C. The carrier plan name or co index to change between rate filings.

5. The base rate PMPM should exclude the pediatric dental rider rate.

Rate Template Part III: Proposed Rate C

Metallic Tier	Metallic Tier Actuarial Value	Standard AV, Approach (1), Approach (2)	Exchange Y or N	Proposed Plan RelavityFactor for 1/1/14	Plan Relativity Factor for 1/1/13
Silver	70.2%	Standard AV	Y	0.75	
Gold	78.6%	Standard AV	Y	0.87	

embership in Rhode Island for the market segment (Individual or Small Group) and product(s) being

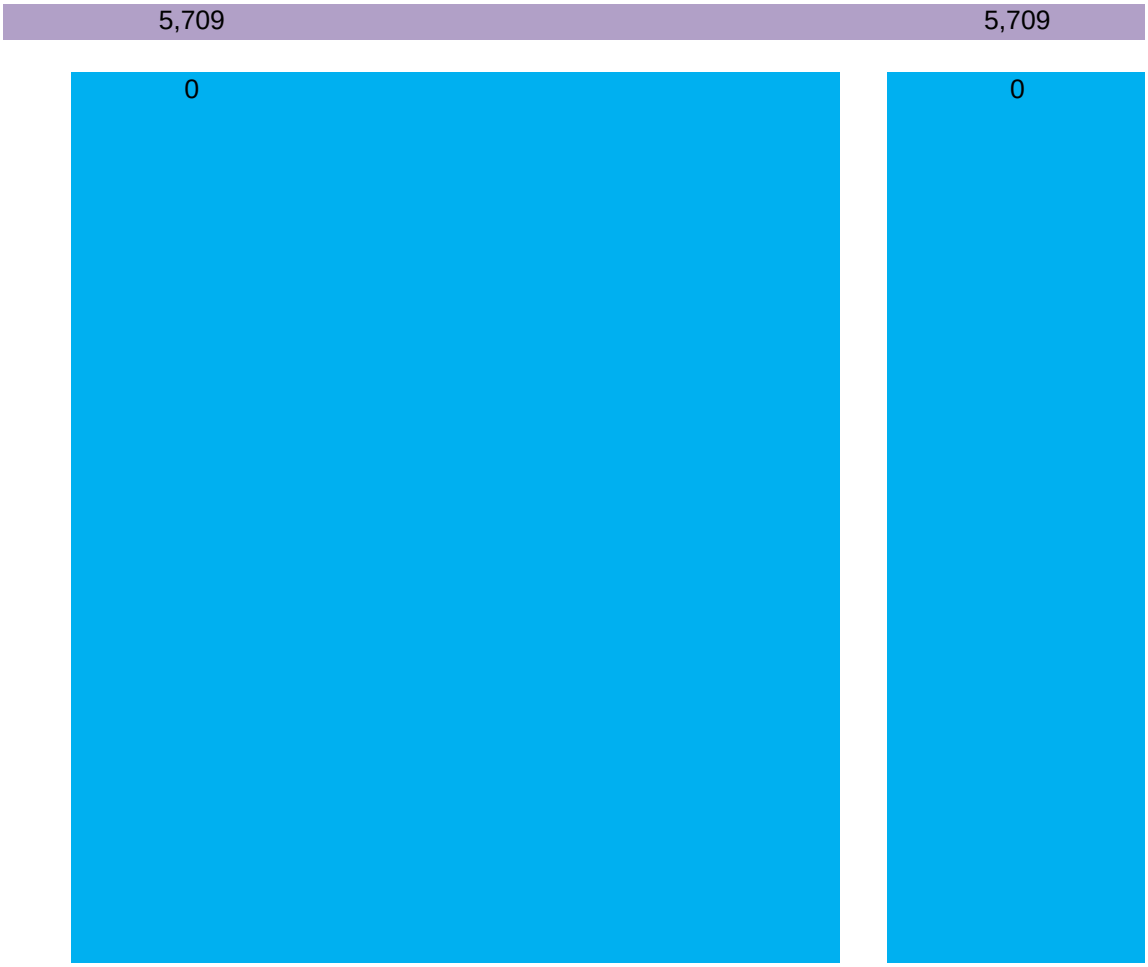
nembership renewing 1/1/14. This should be a subset of columns M-O

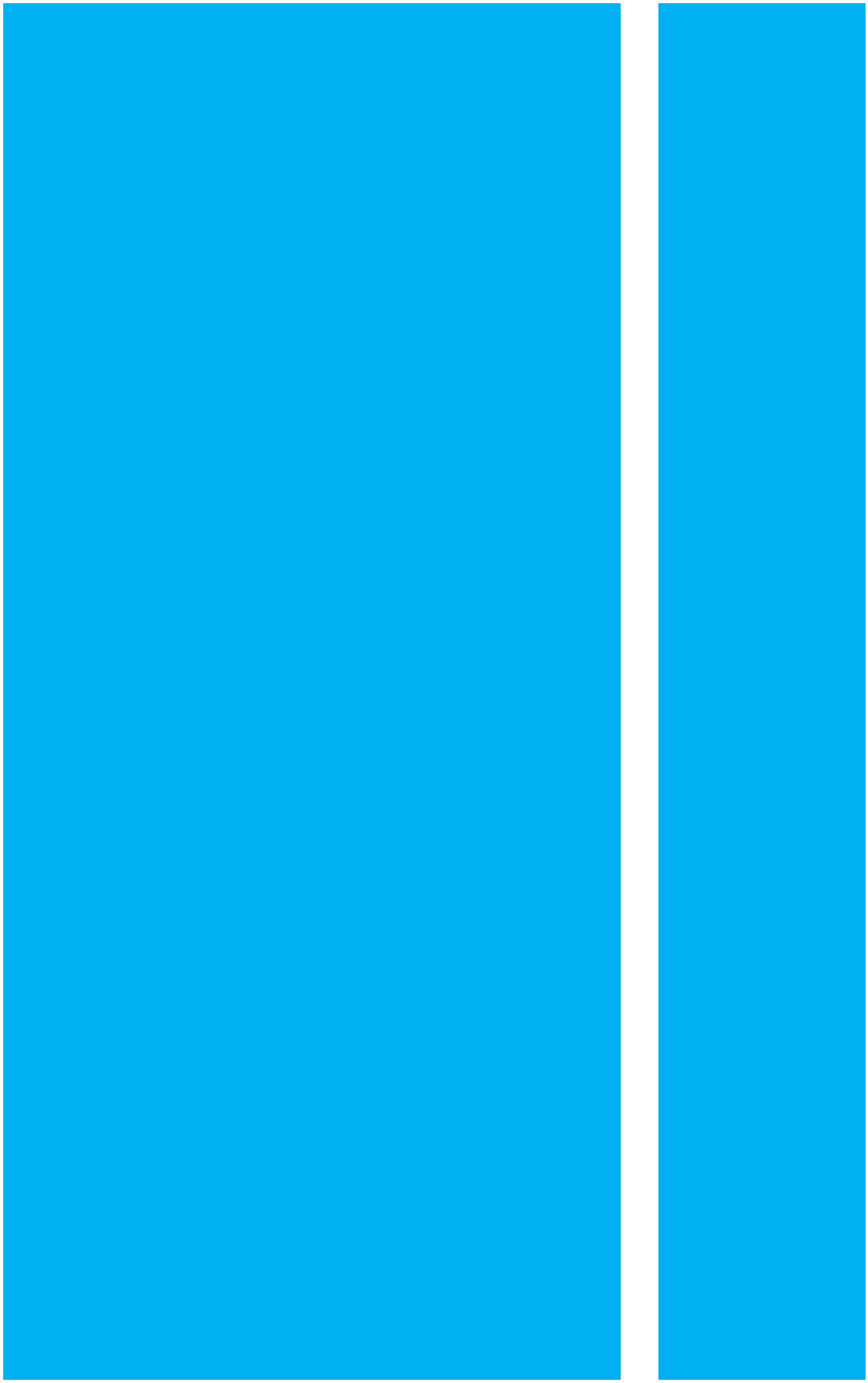
alculate final rates by utilizing the base rate PMPM's in this exhibit and all applicable rating factors,

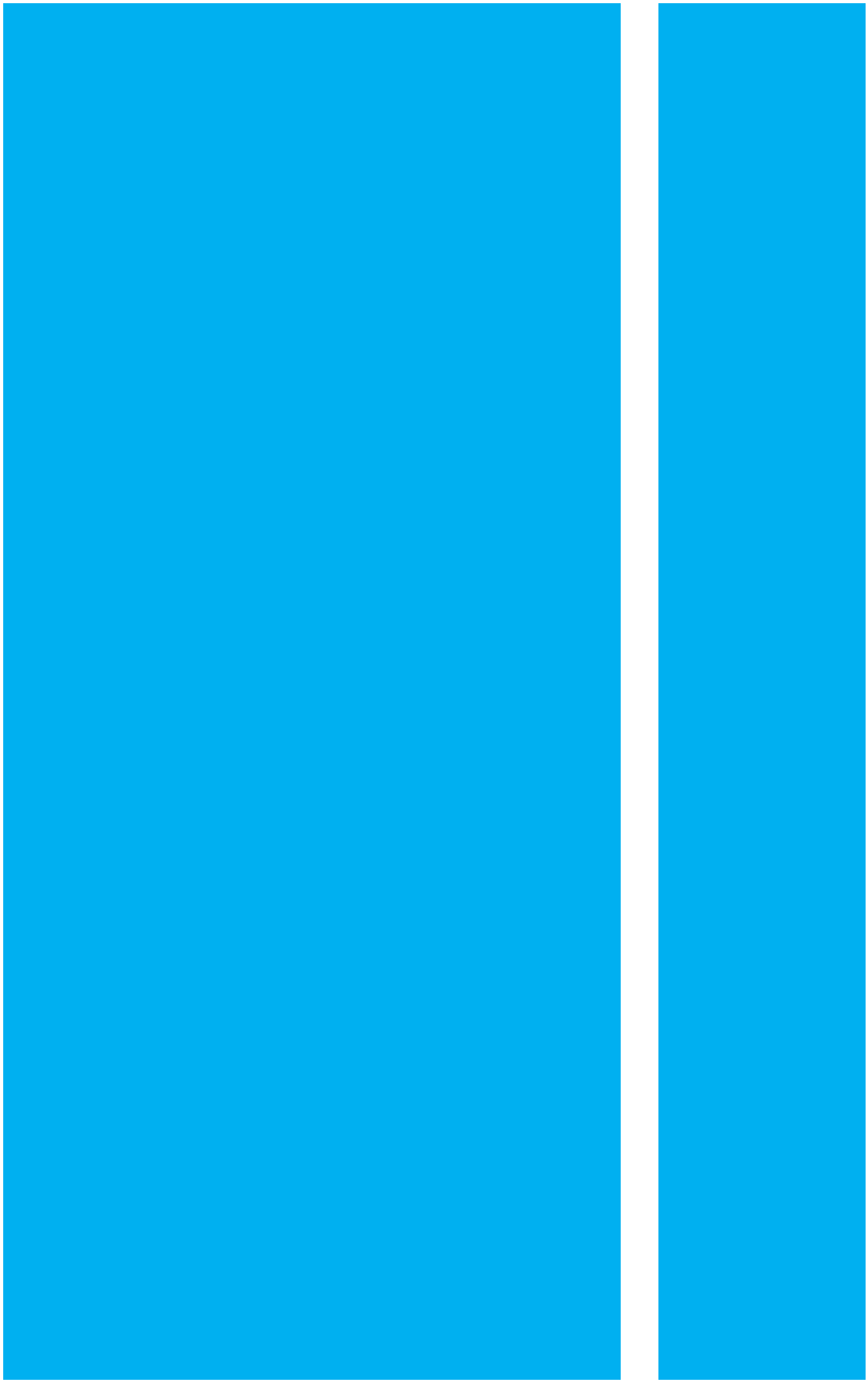
de in column C will correspond to an assigned plan index in column A. We do not expect this plan

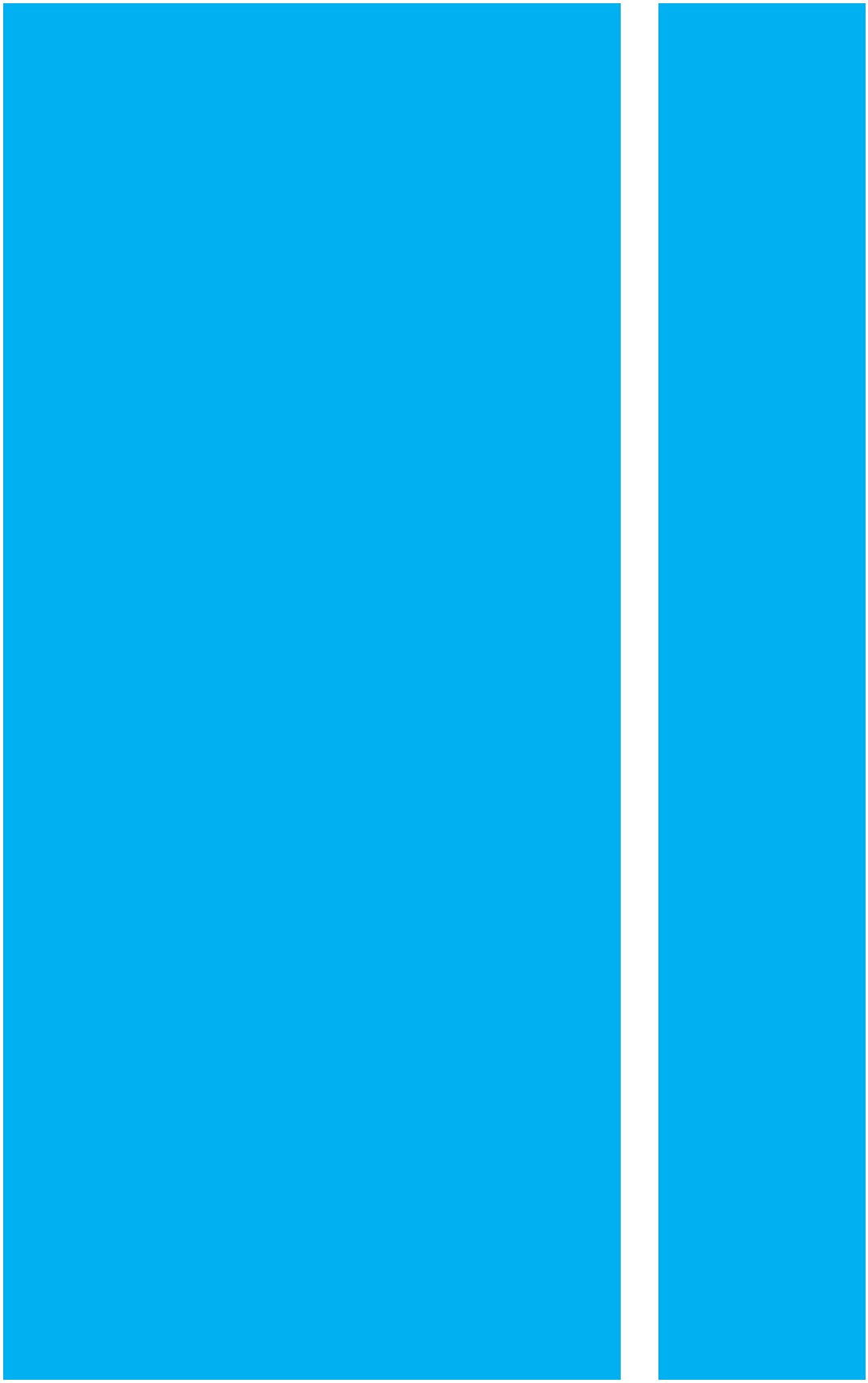
hange and Enrollment by Base Plan Rate PMPM

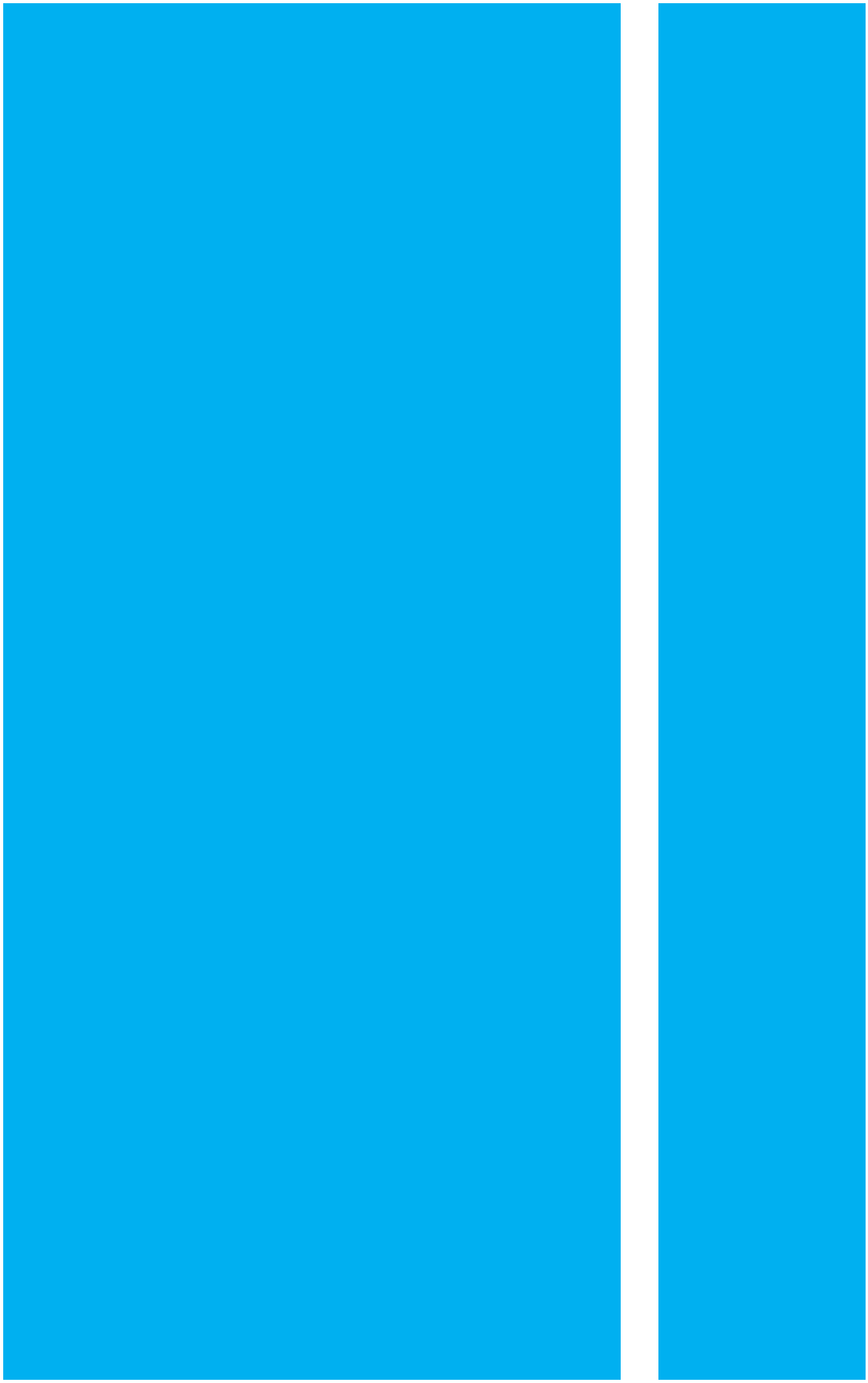
Total Number of Members/Enrolled Policyholders + Covered Dependents[1]	Total Number of Subscribers/Enrolled Policyholders[1]	Total Number of Groups[1]	1/1/14 Number of Members/Enrolled Policyholders + Covered Dependents[2]
5,709	**0**	**0**	**5,709**





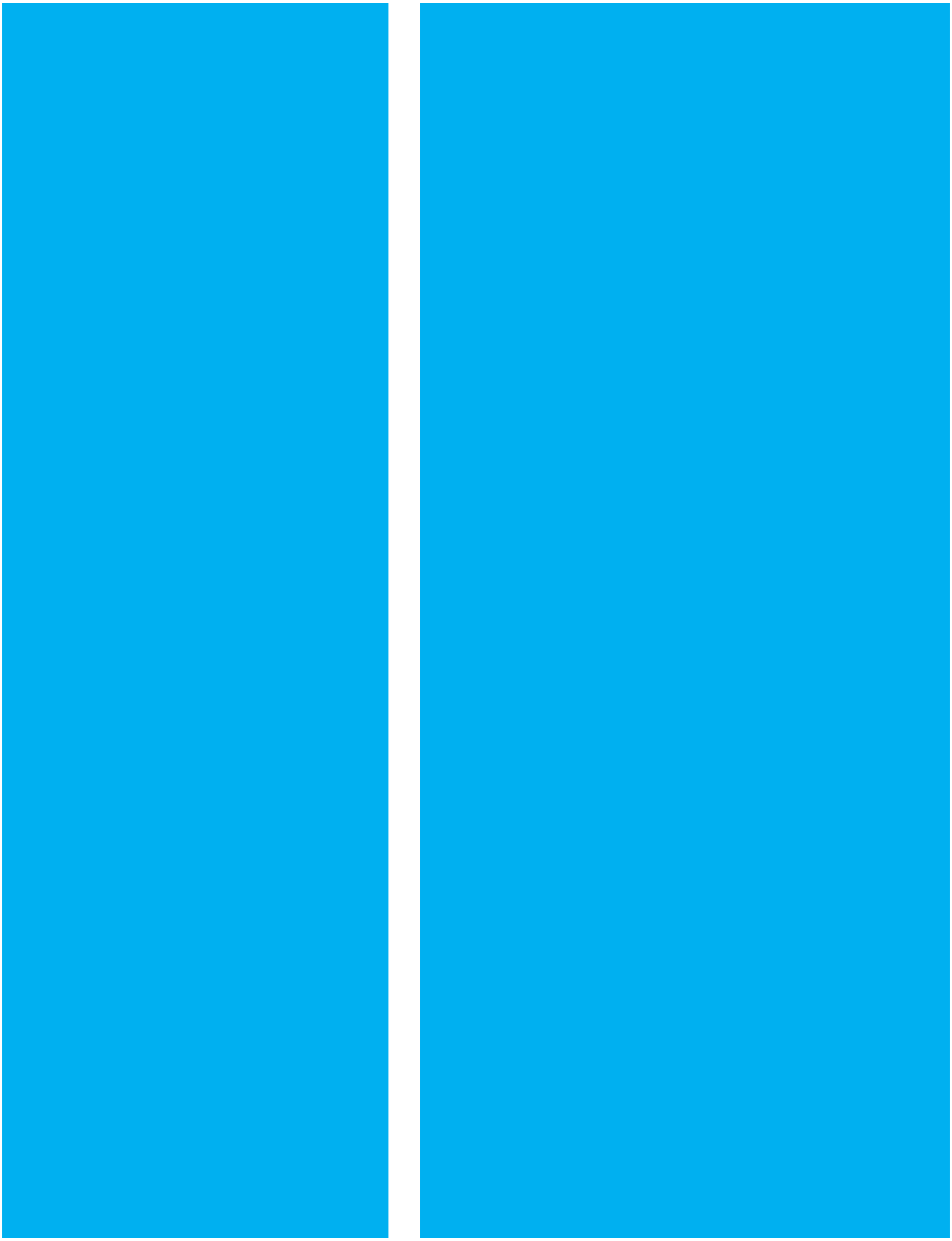


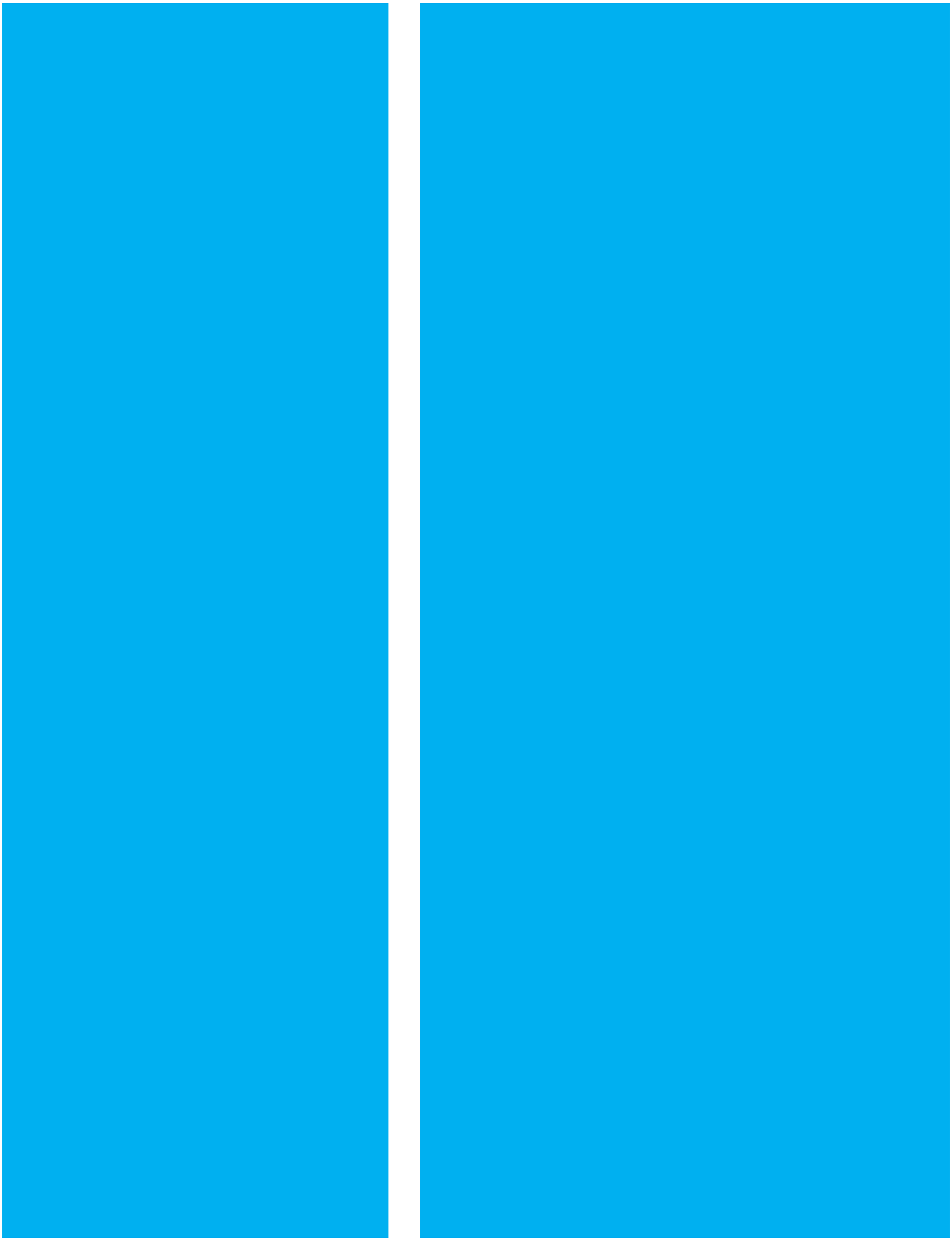


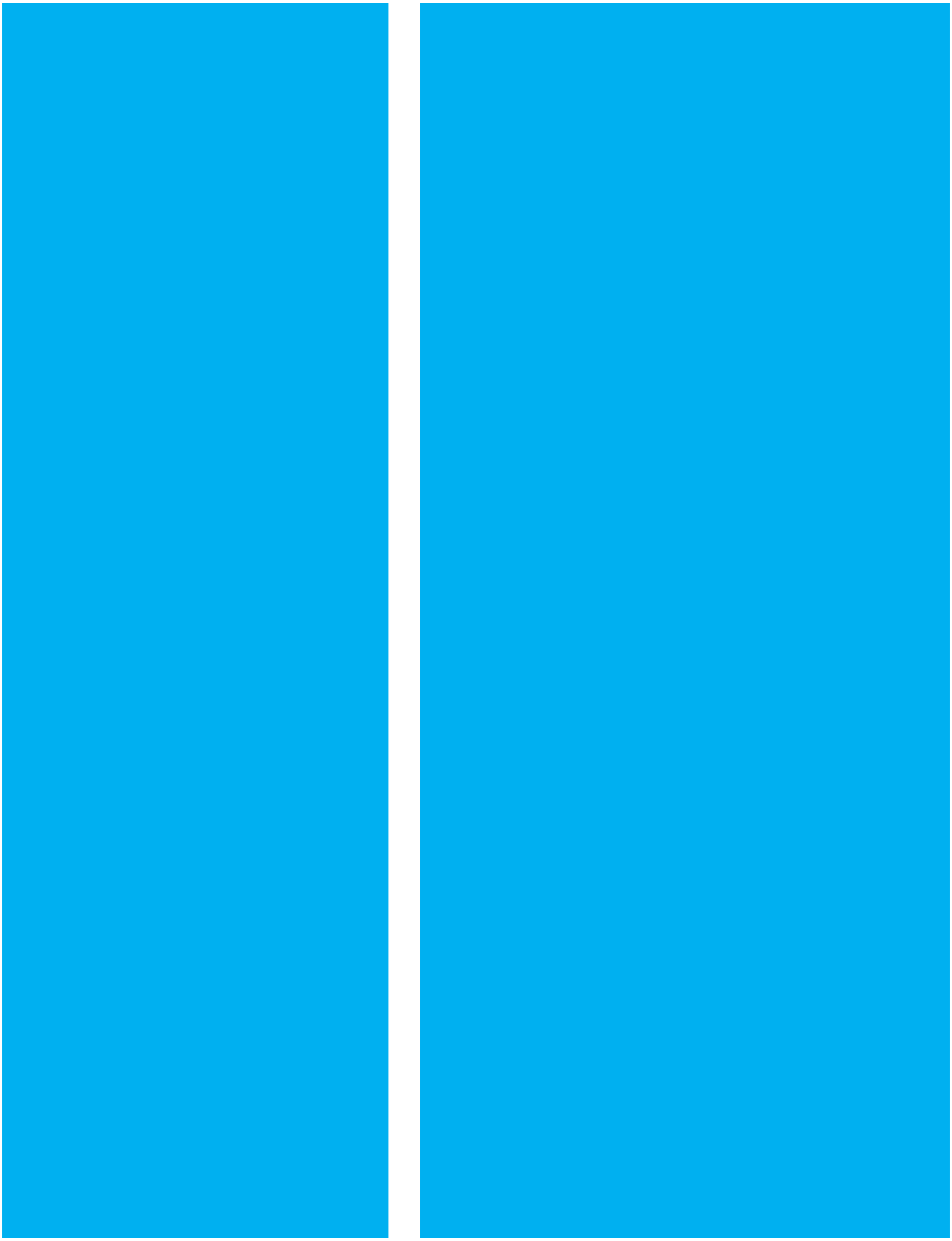


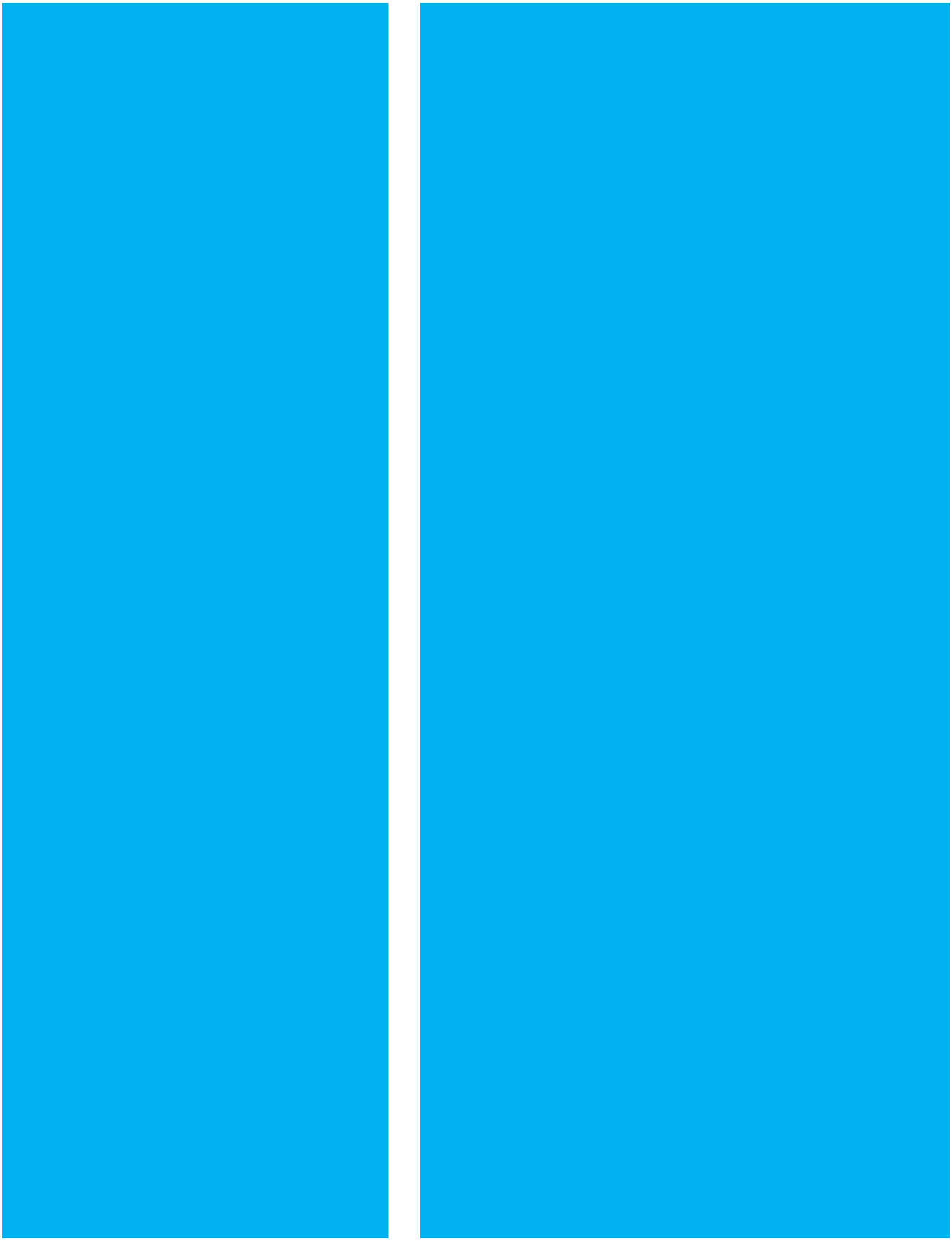
Rate Template Part III: Proposed Rat

1/1/14 Number of Subscribers/Enrolled Policyholders[2]	1/1/14 Number of Groups[2]	Base Plan Rate PMPM in effect 12 months Prior to Rate Effective Date[3]	Proposed Base Plan Rate PMPM for Rate Effective Date[3, 5]
0	0		
		$0.00	$345.99
		$0.00	$345.99
			$345.99
			$345.99









te Change and Enrollment by Base Plan Rate PMPM

Proposed Pediatric Dental Rate PMPM for Rate Effective Date[3]	Proposed Rate Change Compared to Prior 12 months	% of Total Members/Enrolled Policyholders + Covered Dependents	% of 1/1/14 Members/Enrolled Policyholders + Covered Dependents
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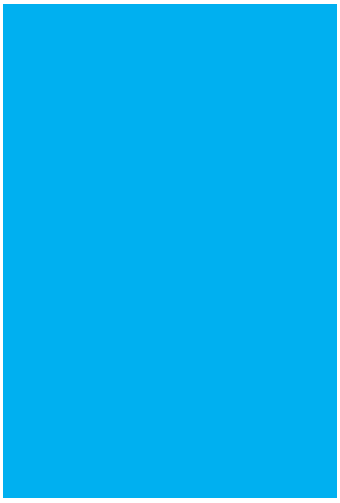

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Rate Template Part IV: Administrative Costs Request

1. Please provide 2012 Actual and 2014 proposed individual, small and large group administrative costs on a per member per month (PMPM) basis, allocated among the National Association of Insurance Commissioners (NAIC) financial statement administrative cost categories. Please explain any significant changes from the financial filing for 2012 (increases/decreases of more than 5% in a particular category).

	2012 Actual			2014 Proposed			% Change		
	Individual	Small Group	Large Group	Individual	Small Group	Large Group	Individual	Small Group	Large Group
Total Estimated Member Months				68,511	12,732		#DIV/0!	#DIV/0!	#DIV/0!
Total Estimated Premiums ($pmpm)				$ 386.52	$ 344.42		#DIV/0!	#DIV/0!	#DIV/0!
Total General Administrative Expense ($pmpm)				$ 48.34	$ 45.82		#DIV/0!	#DIV/0!	#DIV/0!
Total Cost Containment Expense ($pmpm)				$ 11.40	$ 10.82		#DIV/0!	#DIV/0!	#DIV/0!
Total Other Claim Adjustment Expense ($pmpm)				$ 5.40	$ 5.13		#DIV/0!	#DIV/0!	#DIV/0!
Total Admin Expense ($pmpm)				$ 65.14	$ 61.77		#DIV/0!	#DIV/0!	#DIV/0!
Breakdown of General Administrative Expense ($ pmpm)									
a. Payroll and benefits				$18.68	$18.11		#DIV/0!	#DIV/0!	#DIV/0!
b. Outsourced Services (EDP, claims etc.)				$1.93	$1.88		#DIV/0!	#DIV/0!	#DIV/0!
c. Auditing and consulting				$3.11	$3.02		#DIV/0!	#DIV/0!	#DIV/0!
d. Commissions				$0.00	$0.00		#DIV/0!	#DIV/0!	#DIV/0!
e. Marketing and Advertising				$0.64	$0.62		#DIV/0!	#DIV/0!	#DIV/0!
f. Legal Expenses				$0.12	$0.12		#DIV/0!	#DIV/0!	#DIV/0!
g. Taxes, Licenses and Fees				$13.34	$12.50		#DIV/0!	#DIV/0!	#DIV/0!
h. Reimbursements by Uninsured Plans				$0.00	$0.00		#DIV/0!	#DIV/0!	#DIV/0!
i. Other Admin Expenses				$10.52	$9.58		#DIV/0!	#DIV/0!	#DIV/0!

2. Please provide actual 2008-2012 fully insured commercial administrative costs in accordance with the following table. This should be consistent with the annual statement filings to OHIC for adminisrative costs, providing additional detail on the components of administrative costs using the categories defined by the NAIC financial statement and as allocated to commercially insured business only. Specifically, the information provided should agree with the "Exhibit of Premiums, Enrollment and Utilization" and the "Analysis of Operations by Line of Business" schedules included in the annual statements on file with OHIC, Where there are variances, a reconciliation and explanation should be provided.

Fully Insured Commercial Administrative Cost History (Comprehensive Column)					
	2008	2009	2010	2011	2012
Total Premiums					
Total General Administrative Expense					
General Admin Exp. Ratio					
Total Fully Insured Member Months					
General Administrative Expense ($pmpm)					
Breakdown of General Administrative Expenses ($ pmpm)					
a. Payroll and benefits					
b. Outsourced Services (EDP, claims etc.)					
c. Auditing and consulting					
d. Commissions					
e. Marketing and Advertising					
f. Legal Expenses					
g. Taxes, Licenses and Fees					
h. Reimbursements by Uninsured Plans					
i. Other Admin Expenses					
Cost Containment Expense					
Other Claim Adjustment Expense					
Total Self Insured Member Months for all affiliated companies doing business in RI					

Rate Template Part V: Premium Development

A. Development of Base EHB Rate for Projection Period

(A)	(B)	(C)	(D)	(E)	=(A)*(B)/(C)*(D)/(E) (F)	(G)	(H)	(I)	=(F)/[1+(G)+(H)-(I)] (J)
Index Rate for Projection Period	Age Gender Factor of 21 Year Old	Composite Age Gender Factor	Cost Sharing Utilization Factor of Silver 70% Plan	Composite Cost Sharing Utilization Factor	Total Allowed Cost for 21 Year Old Silver Plan	Projected Risk Adjustments	Projected ACA Net Reinsurance Recoveries	Total Retention	Base EHB Rate for Projection Period
$ 481.65	1.00	1.49	1.00	1.00	$ 322.35	2.9%	8.8%	18.49%	$ 345.99

B. Development of Premium Rate for Projection Period

	=(J) (K) Base EHB Rate for Projection Period	(L) Cost Sharing Utilization Factor	(M) Relative AV Factor	=(L)*(M) (N) Plan Relativity Factor	=(K)*(N) (O) Premium Rate for Projection Period
Silver	$ 345.99	1.00	0.75	0.75	$ 258.68
Gold	$ 345.99	1.06	0.82	0.87	$ 300.41

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
04/15/2013		Form	Certificate of Coverages - Individual Market	05/15/2013	Certifcate of Coverage Individual Market - Submission Copy.pdf (Superceded)
04/04/2013		Supporting Document	PPACA Uniform Compliance Summary	05/15/2013	PPACA Uniform Compliance Summary-Individual Market - Submission Copy.pdf (Superceded)
04/04/2013		Supporting Document	Regulation 17	05/15/2013	NHPRI Exchange Product - Individual Market - Reg 17 Checklist - 4-15 Submission Copy.pdf (Superceded)
04/04/2013		Supporting Document	2013 Rate Review Process OHIC Template	05/15/2013	2013 Rate Review Process OHIC Template - NHPRI - Individual.xlsx

Draft Certificate of Coverage

Neighborhood Health Plan of Rhode Island

FRONT INDIV (09-10) ??? SA (04-11)

SUMMARY INDIV (09-10)

WELCOME

Welcome to Neighborhood Health Plan of Rhode Island (NHPRI). Below is a legal notice, some helpful tips, and phone numbers about your plan.

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

This contract is solely between you and Neighborhood Health Plan of Rhode Island. Neighborhood Health Plan of Rhode Island is a Rhode Island non-profit, tax-exempt corporation that was formed by, and continues to be controlled by, Rhode Island's community health centers.

James A. Hooley,
Chief Executive Officer

HELPFUL TIPS

- Read all information provided, especially this Certificate of Coverage. Become familiar with services excluded from coverage (See Section 4.0 – Health Services Not Covered Under This Agreement.)
- In Section 8 – Glossary, there is a list of definitions of words used throughout this agreement. It is very helpful to become familiar with these words and their definitions.
- Identification Cards (ID) are provided to all *members*. The ID card must be shown when obtaining health care services. Your ID card should be kept in a safe location, just like money, credit cards or other important documents. NHPRI should be notified immediately if your ID card is lost or stolen.
- Our list of *network providers* changes from time to time. You may want to call our Customer Service Department in advance to make sure that a *provider* is a *network provider*.
- You are encouraged to become involved in your health care treatment by asking *providers* about all treatment plans available and their costs. You also are encouraged to take advantage of the preventive health services offered under this *agreement* to help you stay healthy and find problems before they become serious.

IMPORTANT TELEPHONE NUMBERS AND WEBSITES

Customer Service - (401) 459-6000 or **1-800-963-1001** or **Voice TDD 1-888-252-5051**. Our normal business hours are Monday - Friday from 8:00 a.m. - 8:00 p.m. Please see Section 1.5 for more details.

Our Website www.nhpri.org

Recommended Preauthorization

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

- **Medical/Surgical -** call our Customer Service Department. Please see Section 1.6 for details.
- **Mental Health and Chemical Dependency -** call 1-800-215-0058before having care. Lines are open 24 hours a day, 7 days per week. Please see Section 1.6 for details

Required Preauthorization

Prescription drugs for which *preauthorization* is required are marked with the symbol (+) in the Summary of Pharmacy Benefits. Please see Section 1.6 and Section 3.29 for more information.

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

SUMMARY OF BENEFITS

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

IMPORTANT NOTE: All of our payments at the benefit levels noted below are based upon a fee schedule called our *allowance*. If you receive services from a *network provider*, the *provider* has agreed to accept our *allowance* as payment in full for *covered health care services*, excluding your *copayments*, *deductible*, and the difference between the *maximum benefit* and our *allowance*, if any. If you receive *covered health care services* from a *non-network provider*, and the services are not an *emergency*, you will be responsible for the *provider's charge*. You will then be reimbursed based on the lesser of the *provider's charge,* our *allowance*, or the *maximum benefit;* less any *copayments* and *deductibles,* if any. The *deductible* and *maximum out-of-pocket expense* are calculated based on the lower of our *allowance* or the *provider's charge,* unless otherwise specifically stated in this *agreement.* We cover emergencies as described in Section 3.7 of this *agreement*.

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

DEPENDENT AGE LIMITS	
Dependent Age	**See Section 2.1 – Who is Eligible for Coverage.**
Dependent Children	The Plan provides coverage for dependents up to age 26 if the Plan offers dependent coverage.

SUMMARY OF MEDICAL BENEFITS

Deductible/Maximum Out-of-Pocket Expense	**Type of Contract**	***Network Provider***	***Non-Network Provider***
Deductible The *deductible* applies to both *network and non-network* services separately.	Single	**($tbd)** per *member* per *contract year*	**($tbd)** per *member* per *contract year*.
	Family	**($tbd)** per family per *contract year*. The *contract year* family *deductible* is met by adding the amount of covered health care expenses applied to the *deductible* for all family *members*; however no one (1) family *member* can contribute more than **($tbd)** towards the *contract year* family *deductible*.	**($tbd)** per family per *contract year*. The *contract year* family *deductible* is met by adding the amount of covered health care expenses applied to the *deductible* for all family *members*; however no one (1) family *member* can contribute more than **($tbd)** towards the *contract year* family *deductible*.
Maximum Out-of-Pocket Expense *(*Prescription drug *copayments,* flat dollar office visit *copayments,* and *copayments* for infertility services do not apply.) The *maximum out-of-pocket expense* accumulates separately for n*etwork and non-network* services.	Single	**($tbd)** per *member* per *contract year*.	**($tbd)** per *member* per *contract year*.
	Family	**($tbd)** per family per *contract year*. The *contract year* family *maximum out-of-pocket expense* is met by adding the amount of covered health care expenses applied to the *maximum out-of-pocket expense* for all family *members*; however no one (1) family *member* can contribute more than **($tbd)** towards the *contract year* family *maximum out-of-pocket expense*.	**($tbd)** per family per *contract year*. The *contract year* family *maximum out of pocket expense* is met by adding the amount of covered health care expenses applied to the *maximum out-of-pocket expense* for all family *members*; however no one (1) family *member* can contribute more than **($tbd)** towards the *contract year* family *maximum out-of-pocket expense*.

Continued	Summary of Medical Benefits		See Important Note from First Page	
Type of Service	Section	Benefit Limit	Level of Coverage *Network Provider*	 *Non-Network Provider*
Ambulance	3.1			
• Ground	3.1		**(%tbd)** coverage less **($tbd)** *copayment* per ambulance service. *Deductible* does not	The *level of coverage* is the same as *network provider.*
• Air/water	3.1	Up to the *maximum benefit* of $3,000 per occurrence.	**(%tbd)** coverage less **($tbd)** *copayment* per ambulance service. *Deductible* does not	The *level of coverage* is the same as *network provider.*
Behavioral Health	3.2			
Mental Health Services	3.2			
• *Inpatient* *	3.2	Unlimited days at a *general hospital* or a *specialty hospital.*	After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
• *Outpatient,* Intermediate Care Services *	3.2	See Section 3.2 for details about partial *hospital program*, intensive *outpatient program*, adult intensive services, and child and family intensive treatment.	After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
• In a *Provider's* office, or in your home	3.2	Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details. Includes individual and individual sessions.	**(%tbd)**coverage less **($tbd)** *copayment* per visit by a *personal physician*, **(%tbd)** coverage less **($tbd)** *copayment* per visit by a specialist. *Deductible* does not apply.	After *deductible* **(%tbd)** coverage
Chemical Dependency Treatment	3.2			
• *Inpatient, Chemical Dependency Treatment Facility* (inpatient)*	3.2	Detoxification – unlimited days Residential/Rehabilitation – unlimited days	After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
• *Outpatient*, In a *Chemical Dependency Treatment Facility (outpatient)*, Intermediate Care Services *	3.2	Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details. See Section 3.2 for details about partial *hospital program*, intensive *outpatient program*, adult intensive services, and child and family intensive treatment.	After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage

Type of Service	Section	Benefit Limit	Level of Coverage: *Network Provider*	Level of Coverage: *Non-Network Provider*
• In a *Provider's* office, or in your home	3.2	Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details. Includes individual and individual sessions.	**(%tbd)** coverage less **($tbd)** *copayment* per visit by a *personal physician*, **(%tbd)** coverage less **($tbd)** *copayment* per visit by a specialist. *Deductible* does not apply.	After *deductible* **(%tbd)** coverage
Cardiac Rehabilitation	3.3			
• *Outpatient*	3.3	Benefit is limited to 18 weeks or 36 visits (whichever occurs first) per covered episode. See Section 3.3 for details.	**(%tbd)** coverage *Deductible* does not apply.	After *deductible* **(%tbd)** coverage
Chemotherapy Services	3.32			
• *Inpatient*	3.32		After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
• *Outpatient*	3.32	Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details.	After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
• In a *doctor's* office	3.32	Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details.	After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
Chiropractic Medicine	3.4	12 visits per *contract year.*	**(%tbd)** coverage less $30 *copayment* per visit. *Deductible* does not apply.	After *deductible* **(%tbd)** coverage
Consultations in the *Hospital*	3.5	Must be requested by *doctor* in charge of your care.	After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
Contraceptive Drugs and Devices	3.6	Coverage varies based on type of contraceptive service. See Section 3.6. Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details.		

Continued	Summary of Medical Benefits		See Important Note from First Page	
Type of Service	Section	Benefit Limit	Level of Coverage *Network Provider*	 *Non-Network Provider*
Diabetic Services	3.7			
• Diabetic equipment/ supplies provided by a licensed medical supply *provider* (other than a pharmacy).	3.7	See Section 3.7 for limitations.	After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
• Diabetic equipment/ supplies purchased at a retail pharmacy.	3.7	See the Summary of Pharmacy Benefits for benefit limits and level of coverage.		
• Office visits	3.7	**Podiatrist Services** First routine visit of a *contract year.* See Section 3.7 for details.	**(%tbd)** coverage *Deductible* does not apply.	After *deductible* **(%tbd)** coverage
	3.7	**Vision Care Service** First routine eye exam of a *contract year* that includes a retinal eye exam.	**(%tbd)** coverage *Deductible* does not apply.	After *deductible* **(%tbd)** coverage
Diagnostic Imaging*, Lab, and Machine Tests	3.8	*Preauthorization* is recommended for certain diagnostic imaging services. See Section 3.8 for details. See Section 3.8 for benefit limitations.		
• *Inpatient*	3.8		After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
• *Outpatient Hospital* Facility	3.8		After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
• *Outpatient* Non-Hospital facility including in a *Doctor's* office, *urgent care center*, or free-standing laboratory	3.8	See Section 3.8 for limitations.	After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
• Diagnostic hearing tests	3.8		**(%tbd)** coverage *Deductible* does not apply.	After *deductible* **(%tbd)** coverage
Doctor's *Hospital* Visits	3.9		After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
Early Intervention Services (EIS)	3.10	Up to the *maximum benefit* of $5,000 per child, from birth to 36 months, per *contract year*. The *provider* must be certified as an EIS *provider* by the Rhode Island Department of Human Services.	**(%tbd)** coverage *Deductible* does not apply.	**(%tbd)** coverage *Deductible* does not apply.

Type of Service	Section	Benefit Limit	Level of Coverage: *Network Provider*	Level of Coverage: *Non-Network Provider*
Emergency Room Services	3.11	See Section 8.0 – definition of *Emergency*.	**(%tbd)** coverage less **($tbd)** *copayment.* ER *copayment* waived if admitted as a *hospital inpatient* within 24 hours. *Deductible* does not apply.	The *level of coverage* is the same as *network provider*.
Experimental/ Investigational Services	3.12	Coverage varies based on type of service. See Section 3.12.		
Hemodialysis Services	3.13			
• *Inpatient*	3.13		After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
• *Outpatient*	3.13		After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
• In your home	3.13		After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
Hemophilia Services	3.14			
• *Outpatient*	3.14	Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details.	After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
• In a *Doctor's* Office	3.14	Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details.	**(%tbd)** coverage less **($tbd)** *copayment* per visit. *Deductible* does not apply.	After *deductible* **(%tbd)** coverage
Home Health Care	3.15	Intermittent skilled services when billed by a home health care agency. Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details.	After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
Hospice Care	3.16	When provided by an approved hospice care *program*. Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details.	After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage

Continued	Summary of Medical Benefits		See Important Note from First Page	
Type of Service	Section	Benefit Limit	Level of Coverage *Network Provider*	 *Non-Network Provider*
Hospital Services *	3.17	Unlimited days at *general hospital* or *a specialty hospital;* maximum of 45 days per *contract year* for physical rehabilitation.	After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
House Calls	3.18	See Section 3.2 - Behavioral Health for benefit information regarding house calls for behavioral health.	**(%tbd)** coverage less **($tbd)** *copayment* per visit by a primary care physician, **(%tbd)** coverage less **($tbd)** *copayment* per visit by a specialist. *Deductible* does not apply.	After *deductible* **(%tbd)** coverage
Human Leukocyte Antigen Testing	3.19	See Section 3.19 for limitations.	After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
Infertility Services	3.20	Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details.	After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
Infusion Therapy	3.21			
• *Inpatient*	3.21		After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
• *Outpatient*	3.21	Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details.	After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
• In the *Doctor's* office, or In your home	3.21	Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details.	After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
Lyme Disease Diagnosis and Treatment	3.22	Coverage varies based on type of service. See Section 3.22.		
Medical Equipment*, Medical Supplies, Enteral Formula and Food, and Prosthetic Devices	3.23	*Preauthorization* is recommended for certain services. See Section 3.23 for details.		
• *Inpatient*	3.23		After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
• *Outpatient*	3.23		After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage

Continued	Summary of Medical Benefits		See Important Note from First Page	
Type of Service	Section	Benefit Limit	Level of Coverage *Network Provider*	 *Non-Network Provider*
• Enteral formula delivered through a feeding tube	3.23	Must be sole source of nutrition.	After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
• Enteral formula or food taken orally*	3.23	Benefit is limited to a *maximum benefit* of $2,500 per *member* per *contract year*. See Section 3.23 for details.	**(%tbd)** coverage	The *level of coverage* is the same as *network provider.*
• Hearing Aid		Coverage is limited to the *maximum benefit* of $700 per ear, per 3-year period per *member*.	After *deductible* **(%tbd)** coverage	The *level of coverage* is the same as *network provider.*
• Hair Prosthesis (Wigs)	3.23	Benefit is limited to the *maximum benefit* of $350 per *member* per *contract year* when worn for hair loss suffered as a result of cancer treatment.	After *deductible* **(%tbd)** coverage	The *level of coverage* is the same as *network provider.*
Office Visits	3.24	Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details. See Section 3.2 - Behavioral Health for level of coverage for office visits related to mental health and chemical dependency services.		
• Allergist and Dermatologist	3.24		**(%tbd)** coverage less **($tbd)** *copayment* per visit. *Deductible* does not apply.	After *deductible* **(%tbd)** coverage
• Asthma Education	3.24		**(%tbd)** coverage *Deductible* does not apply.	After *deductible* **(%tbd)** coverage
• Diabetes Educatio n	3.24	Individual and individual sessions are covered.	**(%tbd)** coverage *Deductible* does not apply.	After *deductible* **(%tbd)** coverage

Continued	Summary of Medical Benefits		See Important Note from First Page	
Type of Service	Section	Benefit Limit	Level of Coverage *Network Provider*	 *Non-Network Provider*

• *Hospital* Based Clinic Visits	3.24		**(%tbd)** coverage less **($tbd)** *copayment* per visit at a *hospital* based clinic, **(%tbd)** coverage less **($tbd)** *copayment* per visit at a hospital based pediatric clinic. *Deductible* does not apply.	After *deductible* **(%tbd)** coverage
• Nutritional Counseling	3.24	Unlimited visits per *contract year* when prescribed by a physician.	**(%tbd)** coverage *Deductible* does not apply.	After *deductible* **(%tbd)** coverage
• Office Visits (other than Pediatric Office Visits)	3.24	One routine adult physical examination and one routine gynecological examination per *contract year* per *member* will be covered.	**(%tbd)** coverage *Deductible* does not apply.	After *deductible* **(%tbd)** coverage
		Sick Visit	**(%tbd)** coverage less **($tbd)** *copayment* per visit by a *personal physician*, **(%tbd)** coverage **($tbd)** *copayment* per visit by a specialist. *Deductible* does not apply.	After *deductible* **(%tbd)** coverage
• Pediatric Office Visits	3.24	Well-Child Office Visits: Birth - 15 months: 8 visits 16 - 35 months: 3 visits36 months - 19 years: 1 per *contract year*.	**(%tbd)** coverage *Deductible* does not apply.	After *deductible* **(%tbd)** coverage
		Sick visit	**(%tbd)** coverage less **($tbd)** *copayment* per visit. *Deductible* does not apply.	After *deductible* **(%tbd)** coverage
• Specialist Visits	3.24	Routine and non-routine visits. See Section 3.2 for benefit information regarding behavioral health.	**(%tbd)** coverage less **($tbd)** *copayment* per visit. *Deductible* does not apply.	After *deductible* **(%tbd)** coverage
• *Urgent Care Center* Visits	3.24	See Section 8.0 – definition of *urgent care center.*	**(%tbd)** coverage less **($tbd)** *copayment* per visit. *Deductible* does not apply.	The *level of coverage* is the same as *network provider.*
Organ Transplants *	3.25	See Section 3.25 for detailed information.	After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage

Continued	**Summary of Medical Benefits**		**See Important Note from First Page**	
Type of Service	Section	Benefit Limit	**Level of Coverage** *Network Provider*	*Non-Network Provider*
Physical/ Occupational Therapy	3.26			
• *Inpatient*	3.26		After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
• *Outpatient* /in a *doctor's/* therapist's office	3.26		After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
Podiatrist Services	3.27	See Section 3.27 for routine foot care exclusions.	**(%tbd)** coverage less **($tbd)** *copayment* per visit. *Deductible* does not apply.	After *deductible* **(%tbd)** coverage
Pregnancy Services and Nursery Care	3.28	Includes pre-natal, delivery, and postpartum services.	After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
Prescription drugs other than *Specialty Prescription drugs,* dispensed and administered by a licensed health care *provider* (other than a pharmacist)	3.29	See Section 3.29 - Prescription Drugs for details.		
• Medications other than injected drugs or infused drugs	3.29	Medications are included in the *allowance* for the medical service being rendered. Includes chemotherapy drugs used for other than cancer treatment.		
• injectable drugs	3.29		After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
• infused drugs	3.29		After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
Prescription Drugs Purchased at a Retail, Specialty, or Mail Order Pharmacy	3.29	See **Summary of Pharmacy Benefits** for benefit limits and level of coverage.		
***Prevention* and Early Detection Services**	3.30	Coverage includes, but is not limited to, the following: mammograms, pap smear, PSA test, flexible sigmoidoscopy, colonoscopy, double contrast barium enema, and fecal occult blood tests. See Section 3.30 for benefit details and limitations.	**(%tbd)** coverage *Deductible* does not apply.	After *deductible* **(%tbd)** coverage

Continued	Summary of Medical Benefits		See Important Note from First Page	
Type of Service	Section	Benefit Limit	Level of Coverage *Network Provider*	 *Non-Network Provider*
• **Adult Immunizations**	3.30		**(%tbd)** coverage *Deductible* does not apply.	After *deductible* **(%tbd)** coverage
• **Pediatric Immunizations**	3.30		**(%tbd)** coverage *Deductible* does not apply.	After *deductible* **(%tbd)** coverage
• **Travel Immunizations**	3.30		**(%tbd)** coverage *Deductible* does not apply.	After *deductible* **(%tbd)** coverage
Private Duty Nursing *	3.31		After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
Radiation Therapy	3.32			
• *Inpatient*	3.32		After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
• *Outpatient*	3.32		After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
Respiratory Therapy	3.33	See *program* requirements in Section 3.33.	After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
Skilled Care in a Nursing Facility *	3.34		After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
Smoking Cessation Programs	3.35			
• Counseling	3.35		**(%tbd)** coverage *Deductible* does not apply.	After *deductible* **(%tbd)** coverage
• Nicotine replacement therapy and smoking cessation prescription drugs	3.35	See the **Summary of Pharmacy Benefits** for level of coverage.		
Speech Therapy	3.36			
• *Inpatient*	3.36		After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
• *Outpatient**	3.36		After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
• In a *doctor's*/ therapist's office*	3.36		After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
Surgery Services	3.37			
• *Inpatient*	3.37		After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage
• *Outpatient/Free-standing Ambulatory Surgi-Center*	3.37		After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage

Continued	**Summary of Medical Benefits**		**See Important Note from First Page**	
Type of Service	Section	Benefit Limit	**Level of Coverage** *Network Provider*	*Non-Network Provider*
• In a *doctor's* office	3.37		**(%tbd)** coverage *Deductible* does not apply.	After *deductible* **(%tbd)** coverage
Vision Care Services	3.38	One routine eye exam per *contract year*.	**(%tbd)** coverage less **($tbd)** *copayment* per visit. *Deductible* does not apply.	After *deductible* **(%tbd)** coverage
Pediatric Vision Diagnostic Eye Exam Eyewear • Lenses • Frames Contact Lenses Other Vision Services	3.39	Service Limits – TBD	1 Exam per year; no charge 1 Pair per year; no charge 1 Pair per year; in lieu of eyeglasses In Network Only; co-pays	Expenses in excess of fee schedule allowances
Habilitative Services Physical/Occupational • Inpatient • Outpatient • In a doctor's/ therapist's office Speech Therapy • Inpatient • Outpatient • In a doctor's/ therapist's office*	3.40	Service Limits - TBD	After *deductible* **(%tbd)** coverage After *deductible* **(%tbd)** coverage	After *deductible* **(%tbd)** coverage After *deductible* **(%tbd)** coverage

Only applies to the Summary of Pharmacy Benefits:

(+) *Preauthorization* is required for certain brand name prescription drugs and certain *specialty prescription drugs*. If *preauthorization* is not obtained, you will be required to pay for the prescription drug at the pharmacy. You can ask us to consider reimbursement after you receive the prescription drug by following the prescription drug *preauthorization* process. For details on how to obtain prescription drug *preauthorization* for a prescription drug, see Section 3.29. For a list of prescription drugs that require *preauthorization*, visit our Web site at nhpri.org or call our Customer Service Department at (401) 459-6000 or 1-800-963-1001.

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

The Summary of Pharmacy Benefits below indicates the tier structure and the corresponding *level of coverage*. The tier placement of our *formulary* is subject to change.

Note: To find out what tier a prescription drug is, call our Customer Service Department at (401) 459-6000 or 1-800-963-1001.

For information about prescription drugs, please see Section 3.29. Included in Section 3.29 are definitions about your Pharmacy Benefits.

SUMMARY OF PHARMACY BENEFITS

PHARMACY PROGRAM
PRESCRIPTION DRUGS PURCHASED AT A RETAIL, SPECIALTY, OR MAIL ORDER PHARMACY

Type and Site of Service	Section	Benefit Limit	Tiers	Level of Coverage *Network Pharmacy*	Level of Coverage *Non-Network Pharmacy*
• **Prescription Drugs, other than *Specialty Prescription Drugs***	3.29				
• when purchased at a Retail or Specialty Pharmacy	3.29	*Copayment* applies per each 30-day supply or portion thereof of maintenance and non-maintenance prescription drugs. You are responsible to pay the lower of your *copayment* or the retail price of the drug.	**Tier 1**	**(%tbd)** coverage less your *copayment* of **($tbd)**	Not covered
			Tier 2	**(%tbd)** coverage less your *copayment* of **($tbd)**	Not covered
			Tier 3	**(%tbd)** coverage less your *copayment* of **($tbd)**	Not covered
			Tier 4	See *specialty prescription drug* section below.	See *specialty prescription drug* section below.

Type of Service	Section	Benefit Limit		Level of Coverage: *Network Pharmacy*	Level of Coverage: *Non-Network Pharmacy*
• when purchased at a Mail Order Pharmacy	3.29	Up to a 90-day supply of maintenance and non-maintenance prescription drugs. You are responsible to pay the lower of your *copayment* or the retail price of the drug. Nicotine replacement therapy and smoking cessation prescription drugs are not covered when purchased at a mail order pharmacy.	**Tier 1**	**(%tbd)** coverage less your *copayment* of **($tbd)**	Not Covered
			Tier 2	**(%tbd)** coverage less your *copayment* of **($tbd)**	Not Covered
			Tier 3	**(%tbd)** coverage less your *copayment* of **($tbd)**	Not Covered
			Tier 4	See specialty prescription drug section below.	See *specialty prescription drug* section below.
• Infertility Prescription drugs, purchased at any Pharmacy	3.29		**Tier 1**	**(%tbd)** coverage	Not Covered
			Tier 2	**(%tbd)** coverage	Not Covered
			Tier 3	**(%tbd)** coverage	Not Covered
			Tier 4	See *specialty prescription drug* section below	See *specialty prescription drug* section below
• Diabetes, Asthma, and COPD prescription drugs	3.29	*Member* must be being treated for certain health conditions		**(%tbd)** coverage less your *copayment* of **($tbd)**.	Not Covered
• Over-the-counter (OTC) preventive drugs, purchased at any pharmacy	3.29	Must be prescribed by a physician. See Section 3.29 for details.		**(%tbd)** coverage	Not Covered
• Nicotine Replacement Therapy and Smoking Cessation Prescription Drugs, purchased at a Retail or Specialty Pharmacy.	3.29	Must be prescribed by a physician. See Section 3.29 for details. Nicotine replacement therapy and smoking cessation prescription drugs are not covered when purchased at a mail order pharmacy.		**(%tbd)** coverage	Not Covered

Type of Service	Section	Benefit Limit		Level of Coverage *Network Pharmacy*	Level of Coverage *Non-Network Pharmacy*
Specialty Prescription Drugs	3.29				
• when purchased at a Specialty Pharmacy	3.29	*Copayment* applies per each 30-day supply or applies per recommended treatment interval.	**Tier 4**	**(%tbd)** coverage less your *copayment* of **($tbd) (+)** You are responsible to pay the lower of your *copayment* or the retail price of the drug.	**(%tbd)** coverage Our reimbursement is based on the *pharmacy allowance.* You are responsible to pay up to the retail cost of the drug.
• when purchased at a Retail Pharmacy	3.29	*Specialty Prescription Drugs* purchased at a Retail Pharmacy are reimbursed at the *non-network* level of coverage.	**Tier 4**	**(%tbd)** coverage Our reimbursement is based on the *pharmacy allowance.* You are responsible to pay up to the retail cost of the drug.	**(%tbd)** coverage Our reimbursement is based on the *pharmacy allowance.* You are responsible to pay up to the retail cost of the drug.
• when purchased at a Mail Order Pharmacy	3.29		**Tier 4**	Not Covered	Not Covered
• Infertility *specialty prescription drugs* purchased at a Specialty Pharmacy (+)	3.29		**Tier 4**	**(%tbd) (+)** coverage Your *copayment* is based on the lower of our *allowance* or the retail cost of the prescription drug.	**(%tbd) (+)** coverage Our reimbursement is based on the *pharmacy allowance.* You are responsible to pay up to the retail cost of the drug.
• Infertility *specialty prescription drugs* purchased at a Retail Pharmacy(+)	3.29	*Specialty Prescription Drugs* purchased at a Retail Pharmacy are reimbursed at the *non-network* level of coverage.	**Tier 4**	**(%tbd) (+)** coverage for *Specialty Prescription Drugs.* Our reimbursement is based on the *pharmacy allowance.* You are responsible to pay up to the retail	**(%tbd) (+)** coverage for *Specialty Prescription Drugs.* Our reimbursement is based on the *pharmacy allowance.* You are responsible to pay up to the retail cost of the drug.
Diabetic equipment and supplies	3.29				
• when purchased at a Retail or Specialty Pharmacy	3.29	Glucometers, Test Strips, Lancet and Lancet Devices, and Miscellaneous Supplies (including calibration fluid). You are responsible to pay the lower of your *copayment* or the retail price of the drug.	**Tier 1**	**(%tbd)** coverage less your *copayment* of **($tbd)**	Not Covered
			Tier 2	**(%tbd)** coverage less your *copayment* of **($tbd)**	Not Covered
			Tier 3	Diabetic equipment and supplies are only placed in Tier 1 or Tier 2. See above.	
			Tier 4		

Type of Service	Section	Benefit Limit		Level of Coverage: *Network Pharmacy*	Level of Coverage: *Non-Network Pharmacy*
• when purchased at a Mail Order Pharmacy	3.29	Glucometers, Test Strips, Lancet and Lancet Devices, and Miscellaneous Supplies (including calibration fluid). You are responsible to pay the lower of your *copayment* or the retail price of the drug.	**Tier 1**	**(%tbd)** coverage less your *copayment* of **($tbd)**	Not Covered
			Tier 2	**(%tbd)** coverage less your *copayment* of	Not Covered
			Tier 3	Diabetic equipment and supplies are only placed in Tier 1 or Tier 2. See above.	
			Tier 4		
Prescription drugs, other than *Specialty Prescription Drugs,* dispensed and administered by a licensed health care *provider* (other than a pharmacist).	3.29	See Summary of Medical Benefits, above.			

Neighborhood Choice
Certificate of Coverage
Neighborhood Health Plan of Rhode Island

TABLE OF CONTENTS

1.0 INTRODUCTION

1.1 Agreement and Its Interpretation

This *agreement* constitutes our entire contract with you. We will make a determination regarding your eligibility for benefits and construe the provisions of this agreement subject to your right to appeal or to take legal action as described in Section 7.0.

This *agreement* may be changed by us at any time. If this *agreement* changes, we will issue an amendment or new *agreement* signed by an officer of Neighborhood Health Plan of Rhode Island. We will mail or deliver written notice of any change to you.

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

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

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

- what health care services are covered under this *agreement;*
- any *benefit limits*, *copayments* and *deductibles* you must pay; and

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

- Section 1.0 - Important Introductory Information;
- Section 2.0 - Information About Eligibility;
- Section 3.0 - Covered Health Care Services;
- Section 4.0 - Health Care Services Which Are Not Covered Under This Agreement;
- Section 5.0 - How We Pay For Your Covered Health Care Services;
- Section 6.0 - How We Coordinate Benefits When You Are Covered By More Than One Plan;
- Section 7.0 - How To File A Claim And How To Appeal A Claim; And
- Section 8.0 - Words With Special Meaning.

1.3 Words With Special Meaning

Some words and phrases used in this *agreement* are in italics. This means that the words or phrases have a special meaning as they relate to your health care coverage. Section 8.0 - Glossary defines many of these words.

The sections below also define certain words and phrases:

- Section 3.0 - Covered Health Care Services;
- Section 6.0 - How We Coordinate Your Benefits When You Are Covered By More Than One Plan;
- Section 7.0 - How To File And Appeal A Claim; and
- Section 7.7 - Our Right of Subrogation and Reimbursement.

1.4 You and Neighborhood Health Plan of Rhode Island

We, Neighborhood Health Plan of Rhode Island, agree to provide coverage for *medically necessary covered health care services* listed in this *agreement.* We only cover a service in

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

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

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

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

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

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

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

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

1.5 Customer Service/General Information

If you have questions about your *benefits* under this *agreement*, call the NHPRI Customer Service Department at (401) 459-6000 or 1-800-963-1001 or Voice TDD 1-888-252-5051. Our normal business hours are Monday - Friday from 8:00 a.m. - 8:00 p.m. If you call after normal business hours, our answering service will take your call. A NHPRI Customer Service Representative will return your call on the next business day. When you call, please have your *member* ID number ready.

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

- To learn if a *provider is a network provider.* You will pay less, or nothing at all, if you receive *non-emergency covered health services* from *network providers;*
- To ask questions and get information about your coverage;
- To file a *complaint* or *administrative appeal* (See Section 7.2);

- To file an appeal about a medical necessity determination or learn about the status of your appeal (See Section 7.3); or
- To ask for a HIPAA (Health Insurance Portability and Accountability Act) certificate of creditable coverage (See Section 2.4 - When Your Coverage Ends).

To find out NHPRI news and *plan* information, visit our Web site at nhpri.org

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

If you have any questions about the medical information in our medical policies, we suggest you give a copy of the medical policy to your *doctor* and talk with your *doctor* about the policy. Please call our Customer Service Department with any questions you have. You are entitled to ask us for the clinical review criteria we use to determine *medical necessity* in a particular situation.

1.6 *[Intentionally Left Blank]*

1.7 Preauthorization

Services for which *preauthorization* is recommended are marked with an asterisk (*) in the Summary of Medical Benefits. *Preauthorization* is defined in Section 8.0. To obtain *preauthorization* for a *covered health care service:*

- For all *covered health care services* (except mental health and *chemical dependency* services please call our Customer Service Department.
- For mental health and *chemical dependency* services please call *[insert Beacon contact info]*.
- Preauthorization lies are open 24 hours a day, 7 days per week.

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

Expedited Preauthorization Review

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

Prescription Drug Preauthorization

Services for which *prescription drug preauthorization* is required are marked with the symbol (+) in the Summary of Pharmacy Benefits. To obtain the required *preauthorization* for certain

covered prescription drugs please request your prescribing physician to call the number listed for the “Pharmacist” on the back of your ID card. You can call our Customer Service Department at (401) 459-6000 or 1-800-963-1001 or visit our Web site at nhpri.org to see if a prescription drug requires *preauthorization*. P*rescription drug preauthorization* is defined in Section 3.29.

1.8 Our Right to Receive and Release Information About You

We are committed to maintaining the confidentiality of your health care information as required by State and Federal laws. These laws permit us to release and receive information about your health, treatment, and condition to or from authorized *providers* and insurance companies, among others, and helps us make available quality, cost-effective health care coverage available to you. We may give or get this information, as permitted by law, for certain purposes, including, but not limited to:

- adjudicating health insurance *claims*;
- administration of *claim* payments;
- health care operations;
- case management and *utilization review*; and
- coordination of health care *benefits.*

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

1.9 Our Right to Approve Alternative Benefits

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

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

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

If we approve an alternative benefit, in order for you to get that benefit you must verbally agree to our specific terms and conditions and sign a letter of *agreement* acknowledging acceptance of the specific terms and conditions of the alternative benefits. We do not make alternative benefits available to all *members*. We do not make them available to any *member* a second time without additional approval. Alternative *benefits* must be consistent with our goals to offer cost-effective health care *benefits*. *Copayments* and *deductibles* for alternative *benefits* will be applied based on how *copayments* and *deductibles* would be applied for similar *covered health care services*.

1.10 Our Right to Conduct Utilization Review

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

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

Although we may conduct *utilization review*, Neighborhood Health Plan of Rhode Island does not act as a health care *provider.* We do not furnish medical care. We do not make medical judgments for you about the care you should receive. You are not prohibited from having a treatment or hospitalization for which reimbursement has been denied. Nothing here will change or affect your relationship with your *provider(s).*

1.11 Your Right to Choose Your Own Provider

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

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

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

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

1.12 How to Select a Health Care Provider

When you select a health care *provider*, refer to the Provider Network Directory to find out if

your health care *provider* is a *network provider*. You may visit our Web site at nhpri.org to find out this information as well.

We do require you to designate a *Primary Care Provider*.

If you travel outside the NHPRI service area and need information or medical care, call _____. For more information about out-of-area *providers*, please see Section 5.3 of this *agreement*.

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

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

2.0 ELIGIBILITY

This section of the *agreement* describes:

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

2.1 Who is an *Eligible Person*

You: Any person is eligible to enroll in coverage under this *agreement*.

Your Spouse: Your spouse is eligible to enroll for coverage under this *agreement* if you have selected family coverage. Only one of the following individuals may be enrolled at a given time:

- Your opposite sex spouse, according to the statutes of the state in which you were married, when your marriage was formed by obtaining a marriage license, having a marriage ceremony, and registering the marriage with the appropriate state or local official.
- Your common law spouse, according to the law of the state in which your marriage was formed (generally, common law spouses are of the opposite-sex). Your spouse by common law of the opposite gender is eligible to enroll for coverage under this *agreement.* To be eligible, you and your common law spouse must complete and sign our Affidavit of Common Law Marriage and send us the necessary proof. Please call us to obtain the Affidavit of Common Law Marriage.
- Your same-sex spouse, according to the laws of the state in which you were married, when your marriage was formed by obtaining a marriage license, having a marriage ceremony, and registering the marriage with the appropriate state or local official. Your same-sex spouse may be enrolled only if your marriage is recognized by the state in which you reside.
- Your civil union partner, according to the law of the state in which you entered into a civil union. Civil Union partners may be enrolled only if civil unions are recognized by the state in which you reside.
- Former Spouse: In the event of a divorce, your former spouse will continue to be eligible for coverage provided that your divorce decree requires you to maintain continuing coverage under a family policy in accordance with state law. In that case, your former spouse will remain eligible on your policy until the earlier of:
  i. the date either you or your former spouse are remarried;
  ii. the date provided by the judgment for divorce; or
  iii. the date your former spouse has comparable coverage available through his or her own employment.

Domestic Partner: Your domestic partner is eligible to enroll for coverage under this *agreement*. You and your domestic partner must complete and sign our Declaration of Domestic Partnership and we must receive necessary proof.

Your Children: Each of your and your spouse's children are eligible for coverage up to the maximum dependent age shown in the Summary of Benefits, or as ordered by a Qualified Medical Child Support Order ("QMCSO"). For purposes of determining eligibility under this *agreement*, the term child means:

- Natural Children;
- Step-children;
- Legally Adopted Children: In accordance with Rhode Island General Law § 27-20-14, an adopted child will be considered eligible for coverage as of the date of placement for adoption with you by a licensed child placement agency;
- Foster Children: Your foster children who permanently live in your home are eligible to enroll for coverage under this *agreement.*

We may request more information from you to confirm your child's eligibility.

Disabled Dependents:
In accordance with Rhode Island General Law § 27-20-45, when your unmarried child who is enrolled for coverage under this *agreement* reaches the maximum dependent child age indicated in the Summary of Benefits and is no longer considered eligible for coverage, he or she continues to be an *eligible person* under this *agreement* if he or she is a disabled dependent:

If you have an unmarried child of any age who is medically certified as disabled and is chiefly dependent on you for support and care because of mental impairment or physical disability, which can be expected to result in death or can be expected to last for a continuous period of not less then twelve months, that child is an eligible dependent under this *agreement.* If you have a child whom you believe satisfies these conditions, you must call us to obtain the form necessary to verify the child's disabled status and show proof of the disability. This form must be filled out and submitted to us. Periodically thereafter, you may be asked to show proof that this disabling condition still exists to maintain coverage as a dependent for this child.

2.2 When Your Coverage Begins

When First Eligible

When First Eligible

You and your eligible dependents may enroll by making written application to us through the *Exchange*. So long as we receive your membership application within that timeframe and your membership fees are paid, your coverage begins on the first day of the month following your submission of a complete application to us.

Special Enrollment Period
After your initial effective date, you may enroll your eligible dependents for coverage through a Special Enrollment Period after you or your eligible dependents experience a change in family status, a loss of private health coverage, or a change in eligibility for Medicaid or a State Children's Health Insurance Program (CHIP) as described below.

With a change in family status, you must make written application within the thirty-one (31) days following the event. You and/or your eligible dependents will qualify for a Special Enrollment Period as follows:

- if you get married, coverage begins the first day of the month following your marriage;
- if you have a child born to the family, coverage begins on the date of the child's birth;
- if you have a child placed for adoption with your family, coverage begins on the date the child is placed for adoption with your family.

With a loss of private health coverage, you must make written application within the thirty-one (31) days following the event. Coverage begins the first day of the month following the loss of private health coverage. If you or your eligible dependents have a loss of coverage on the first day of the month, coverage under this *plan* begins on the first day of that month. You or your eligible dependents will qualify for a Special Enrollment Period if each of the following conditions is met:

- The *eligible person* seeking coverage had other coverage at the time that he or she was first eligible for coverage under this *agreement*;
- The person waived coverage under this *plan* due to being covered on another plan; and
- The coverage on the other plan is terminated as a result of:
  - loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment),
  - *employer* contributions towards such coverage being terminated, or
  - COBRA, due to continuation, is exhausted.

With a change in eligibility for Medicaid or a CHIP, you must make written application within sixty (60) days following your change in eligibility. Coverage will begin on either the first day of the month following the event or, if the event occurs on the first day of a month, coverage under this *plan* begins on the first day of that month. You and/or your eligible dependents will qualify for a Special Enrollment Period as follows:

- you and/or your eligible dependent are terminated from Medicaid or CHIP coverage due to a loss of eligibility; or
- you and/or your eligible dependent become eligible for premium assistance, coverage, through Medicaid or CHIP.

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

Late Enrollment: You and/or your eligible dependents may enroll following the initial enrollment period, and outside of the open enrollment or special enrollment periods. Coverage is effective the first day of the calendar month following the receipt of your completed application.

2.3 How to Add or Remove Coverage for Family Members

You must notify us if you want to add family *members* according to the provisions described above in Section 2.2.

If you want to remove family *members* from your coverage, you must also notify us in advance of the requested removal date.

To add or remove coverage, please call NHPRI Customer Service at _____.

2.4 When Your Coverage Ends

When We May End This Agreement

NHPRI may only end this *agreement and* your health insurance coverage by us if:

- You cease to be an *Eligible Person;*
- You are no longer eligible for coverage through the *Exchange*;
- You fail to pay premiums after all your grace periods have passed;
    - If you are a *member* who receives advance payments of premium tax credit, you will have a 3 month grace period and we must provide you with advance notice that your payments are late, unless the *Exchange* has accepted the obligation to do so instead of NHPRI.
    - For all other *members*, we will give you notice of late payment and a 30 day grace period before your insurance by us will end.
- Your coverage is rescinded for a legally permitted reason.
- NHPRI is terminated or decertified as a plan on the *Exchange*.
- You change from one *plan* to another through during an open or special enrollment period.

If you decide to discontinue coverage, we must receive your notice to end this *agreement* prior to the requested date of cancellation. If we do not receive your notice prior to the requested date of cancellation, you may be responsible for paying another month's membership fees.

This *agreement* will end for a covered dependent if the dependent no longer qualifies as an *eligible dependent*.

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

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

2.5 Continuation of Coverage

Coverage is guaranteed renewable, and the Issuer may non-renew or cancel coverage under the Plan only for nonpayment of premiums, fraud, market exit, movement outside of service area, or cessation of bona-fide association membership.

Extended Benefits *[Beth to ask Milliman if this Section is relevant to the NHPRI Plan]*

If you are totally disabled on the day your agreement ends and you require continued care, your coverage will continue for twelve (12) months if:
(a) the service provided is listed as a covered *benefit* under this agreement; AND
(b) the care you receive relates to or arises out of the disability you had on the day this agreement ended.

Extended *benefits* apply ONLY to the *subscriber* who is totally disabled. If you desire to receive coverage for continued care upon termination of this agreement, you must provide us with proof that you are totally disabled. We will make a determination whether your condition constitutes a total disability and you will have the right to appeal our determination or to take legal action as described in Section 7.0.

Your coverage will NOT be continued if you become eligible for coverage under another *plan*.

3.0 COVERED HEALTH CARE SERVICES

We agree to provide coverage for *medically necessary covered health care services* listed in this *agreement.* If a service or category of service is not specifically listed as covered, it is not covered under this *agreement.* Only services that we have reviewed and determined are eligible for coverage under this *agreement* are covered. All other services are not covered. See Section 1.4 for how we identify *new services* and our guidelines for reviewing and making coverage determinations.

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

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

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

Also coverage differs depending on whether:

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

NHPRI does not limit eligibility or coverage based on a person's genetic information. This means we will not:

(i) change your premium payments based on genetic information;
(ii) request or require you to receive genetic testing; or
(iii) collect genetic information from you or your *eligible dependents* prior to, or in connection with enrollment in a *plan*, or at any time for underwriting purposes.

Please see the Summary of Benefits at the front of this *agreement* to determine the *benefit limits* and *level of coverage* we provide for the *covered health care services* in this *agreement.*

3.1 Ambulance Services

Ground Ambulance

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

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

- to the closest available *hospital* for an *inpatient* admission;
- from a *hospital* to home or to a skilled nursing facility or to a rehabilitation facility

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

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

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

Air and Water Ambulance
Medically necessary air and water ambulance services are covered as listed in the Summary of Benefits.

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

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

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

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

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

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

Related Exclusions
This *agreement* does NOT provide coverage for:
- air or water ambulance transportation unless the destination is an acute care *hospital*. (some examples of non-covered air or water ambulance services include transport to a physician's

- office, nursing facility, or a patient's home); and
- transport from cruise ships when not in United States waters.

3.2 Behavioral Health Services

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

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

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

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

NHPRI provides behavioral health services in parity with all other *covered health services*. This means that:

- Coverage for the medical treatment of mental illness and substance abuse will be provided under the same terms and conditions as that coverage is provided for other illnesses and diseases.

- ***[Per Milliman: describe, through illustrations, FAQ's, or other consumer explanation how the Plan provides for Parity in connection with financial requirements, quantitative treatment limitations, prescription drug benefits, and non-quantitative treatment limitations.]***

A. Mental Health Services Inpatient

If you are an *inpatient* in a *general* or *specialty hospital* for mental health services, we cover *medically necessary hospital services* and the services of an attending physician. See Section 3.16 - *Hospital Services* for additional information.

Outpatient/ Intermediate Care Services

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

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

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

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

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

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

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

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

In a Provider's Office/In your Home

We cover the following mental health specialists:

- Psychiatrists;
- Licensed clinical psychologists;

- Clinical social workers (licensed or certified at the independent practice level);
- Licensed nurse clinicians (with a masters degree in nursing and certification by the ANA as a clinical specialist in psychiatric and mental health nursing);
- Licensed mental health counselor; AND
- Licensed marriage and family therapists.

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

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

We cover medication visits as an office visit when rendered by a psychiatrist or a clinical nurse specialist in behavioral health. See Section 3.24 - Office Visits.

For prescription drug coverage, see Section 3.29 - Prescription Drugs and Diabetic Equipment/Supplies. See the Summary of Pharmacy Benefits for *benefit limits* and *level of coverage*.

Electroconvulsive Therapy
We cover electroconvulsive therapy (ECT) services when performed and billed by a psychiatrist. We cover anesthesia services when rendered by an anesthesiologist. See Section 3.37 Surgery Services - Anesthesia Services.

Related Exclusions
This *agreement* does NOT cover the following mental health services:
- Recreation therapy, non-medical self-care, or self-help training;
- Mental health residential treatment programs (including eating disorder residential treatment programs) and mental health services performed in a residential treatment facility or in the portion of a *hospital,* or any *inpatient* facility, used for residential treatment purposes. We review the program, *hospital* or *inpatient* facility and the specific services provided to decide whether a program, *hospital* or *inpatient* facility meets our medical guidelines and criteria;
- Telephone consultations (See Section 4.16);
- Therapeutic recreation programs or wilderness programs;
- Services provided in any covered *program* that are reviewed by us and we decide are recreation therapy programs, wilderness programs, or non-clinical services; and
- Behavioral training assessment, education or exercises, including applied behavioral analysis.

This *agreement* does NOT cover mental health services when:
- the *provider* does NOT meet the eligibility and/or credentialing requirements; or
- the *program* is not approved by us.

This *agreement* does NOT cover treatment at facilities that are not approved and/or licensed by the state in which the facility is located. See Section 4.6 for Services Provided by Facilities We Have Not Approved and Section 4.8 for Services Performed by People/Facilities Who Are Not Legally Qualified or Licensed.

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

Chemical Dependency Treatment, below.

B. Chemical Dependency Treatment

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

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

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

Related Exclusions

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

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

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

This *agreement* does NOT cover treatment at facilities that are not approved and/or licensed by the state in which the facility is located. See Section 4.6 for Services Provided by Facilities We Have Not Approved and Section 4.8 for Services Performed by People/Facilities Who Are Not Legally Qualified or Licensed.

Inpatient/ Chemical Dependency Treatment Facility

We cover the following *inpatient chemical dependency* services:

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

Outpatient/Chemical Dependency Treatment Facility/ Intermediate Care Services

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

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

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

- **Partial Hospital Program (PHP)** – We cover partial *hospital programs* that are approved by us and meet our criteria for participation. This *program* must be available for a minimum of five

- (5) hours per day five (5) days per week. It must consist of, but not limited to, individual, individual, and family therapy, medication evaluation and management services. The *program* must be available 24 hours a day 7 days per week for support of the patient. This *program* must provide substantial clinical support to patients who are either in transition from the *hospital* to an *outpatient* setting or at risk for admission to *inpatient* care or other higher levels of care.

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

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

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

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

  The program requires the health care *provider* to render a minimum of six (6) contact hours per week. CFIT benefits are available only for covered dependent children up to the age of 26

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

Related Exclusions
This *agreement* does NOT cover methadone clinics and treatments. See Section 4.6 - Services Provided By Facilities We Have Not Approved and Section 4.8 - Services Performed by People/Facilities Who Are Not Legally Qualified or Licensed.

3.3 Cardiac Rehabilitation

Outpatient
We cover *medically necessary* visits in a cardiac rehabilitation *program*. See the Summary of Medical Benefits for *benefit limits* and *level of coverage*.

3.4 Chiropractic Medicine

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

For information about medical equipment and supplies, see Section 3.23 - Medical Equipment, Medical Supplies, and Prosthetic Devices.

Related Exclusions
This *agreement* does NOT cover:
- massage therapy, aqua therapy, maintenance therapy, and aromatherapy;
- therapies, procedures, and services for the purpose of relieving stress;
- pillows;
- x-rays read by a chiropractic physician; and
- chiropractic services received in your home.

3.5 Consultations in the Hospital

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

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

3.6 Contraceptive Drugs and Devices

In accordance with Rhode Island General Law §27-20-43, this *agreement* provides coverage for FDA approved contraceptive drugs requiring a prescription and devices requiring a prescription. The following list is based on the most current FDA approved contraceptive drugs and devices requiring a prescription and is subject to change:
- surgical insertion, removal and removal with reinsertion of contraceptive implants. Contraceptive implants are included in our *allowance* for the surgical insertion/reinsertion procedure. See Section 3.37 Surgery Services for how we cover surgical services.
- surgical implantation and removal of intrauterine device (IUD). The IUD is included in our *allowance* for the surgical implantation procedure. See Section 3.37 Surgery Services for how we cover surgical services.
- diaphragms supplied in a *doctor's* office are covered as a medical supply and subject to the *level of coverage* for medical equipment, medical supplies, and prosthetic devices received

- as an *outpatient*. See Section 3.23 Medical Equipment, Medical Supplies, and Prosthetic Devices.
- injectable contraceptive prescription drugs supplied and administered by a *doctor* are covered as an injectable prescription drug dispensed and administered by a licensed health care *provider* (other than a pharmacist). See Section 3.29 Prescription Drugs.
- prescribed oral contraceptives, contraceptive patches, diaphragms, and injectable contraceptive prescription drugs purchased at a *network pharmacy* are covered as a prescription drug purchased at a pharmacy. See Section 3.29 Prescription Drugs.

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

Related Exclusions

A church or qualified church-controlled organization as defined in 26 USC 3121 may opt to exclude coverage for contraceptive drugs and devices. See Summary of Benefits to determine coverage of contraceptive drugs and devices, if any.

3.7 Diabetic Equipment/Supplies

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

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

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

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

Some diabetic equipment and supplies can be bought at a *network* pharmacy. When bought at a *network* pharmacy*,* the covered diabetic equipment and supplies are subject to the *benefit limits* and *level of coverage* shown in the Summary of Pharmacy Benefits. See Section 3.29 - Prescription Drugs.

In addition, to the *benefit limits* and *level of coverage* shown in the Summary of Benefits, we cover office visits to a podiatrist and to an optometrist or ophthalmologist for members with diabetes. We cover other office visits. For office visits to a podiatrist, see Section 3.27 - Podiatrist Services. For vision care, see Section 3.38 – Vision Care Services.

3.8 Diagnostic Imaging, Lab, and Machine Tests

Inpatient/Outpatient/In a Doctor's Office

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

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

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

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

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

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

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

If a diagnostic imaging, lab or machine test service is rendered and a surgical procedure is performed at the same time, the *level of coverage* for each service is based on the type of service being rendered. For surgical services (including but not limited to biopsies, lesion removals, or endoscopies) see Section 3.37 Surgery Services. For diagnostic imaging, labs, or machine tests see Section 3.8 - Diagnostic Imaging, Lab and Machine Tests.

For *Preventive Care Services* and Early Detection Services, see Section 3.30.

Related Exclusions

This *agreement* does NOT cover the following:

- re-reading of diagnostic tests by a second *doctor;*
- dental X-rays (except when ordered by a *doctor*/dentist to diagnose a condition due to an accident to your *sound natural teeth*. See Section 3.11 - Emergency Room Services for details);
- bone marrow blood supply MRI;
- genetic testing for screening purposes;
- audiometric hearing or speech services if another entity or agency is responsible for such services under state or federal laws which provide service for the health of school children or children with disabilities. (See generally, Title 16, Chapters 21, 24, 25, and 26 of the Rhode

Island General Laws. See also regulations about the health of school children and the special education of children with disabilities or similar rules set forth by federal law or state law of applicable jurisdiction.);
- over the counter diagnostic devices or kits even if prescribed by a physician, except for those devices or kits related to the treatment of diabetes;
- home sleep studies, unless administered and attended by a sleep technologist; or
- nicotine lab tests.

3.9 Doctors' Hospital Visits

For coverage of surgeons, see Section 3.37 - Surgery Services.

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

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

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

3.10 Early Intervention Services (EIS) In accordance with Rhode Island General Law §27-20-50, this *agreement* provides coverage for Early Intervention Service. Early Intervention Services are educational, developmental, health, and social services provided to children from birth to 36 months. The children must have been certified by the Rhode Island Department of Human Services to enroll in an approved Early Intervention Services *program.* Services must be provided by a licensed Early Intervention *provider* and rendered to a Rhode Island resident. We cover Early Intervention Services as defined by the Rhode Island Department of Human Services including, but not limited to, the following:
- speech and language therapy;
- physical and occupational therapy;
- evaluation;
- case management;
- nutrition;
- service plan development and review;
- nursing services; and
- assistive technology services and devices.

See the Summary of Medical Benefits for the *maximum benefit* limit and *level of coverage*.

Related Exclusions

This *agreement* does NOT cover early intervention services when the services:
- are provided by a non-licensed early intervention *provider;* or
- the services are rendered to a non-Rhode Island resident.

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

your *doctor* or use an *urgent care center*.

If you have an accident or medical *emergency* that needs emergency room services and your first visit to the emergency room occurs within twenty-four (24) hours of the accident or onset of symptoms, we cover the *hospital* emergency room services and the *doctor's* services.Bandages, crutches, canes, collars, and other supplies incidental to your treatment in the emergency room are covered as part of our *allowance* for the emergency room services.

When physician services are rendered in the emergency room, other than the emergency room physician examination, the *level of coverage* is based on the type of service being rendered. For surgery services (including but not limited to sutures, fracture care, and other surgical procedures), see Section 3.37 - Surgery Services. For a specialist exam, see Section 3.24 - Office Visits. For diagnostic imaging, lab and machine tests, see Section 3.8. See the Summary of Benefits for *benefit limits* and *level of coverage* for each type of service.

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

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

If you receive these services in a *doctor*/dentist's office, you are responsible for any applicable office visit *copayment.* See Section 3.24 - Office Visits.

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

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

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

Related Exclusions

This *agreement* does NOT cover:

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

3.12 Experimental/Investigational Services and Clinical Trials

This *agreement* provides coverage for *experimental/investigational* services as required by Rhode Island General Laws Sections § 27-18-24 et seq.

This means that if you are participating in a phase I, phase II, phase III or phase IV clinical trial that is conducted by a *network* provider in relation to the prevention, detection or treatment of cancer or a life-threatening disease or condition and is described in any of the following:

(A) The study or investigation is approved or funded, which may include funding through in-kind contributions, by one or more of the following:

(i) The federal National Institutes of Health;

(ii) The federal Centers for Disease Control and Prevention;

(iii) The federal Agency for Health Care Research and Quality;

(iv) The federal Centers for Medicare & Medicaid Services;

(v) A cooperative individual or center of any of the entities described in items (i) through (iv) or the U.S. Department of Defense or the U.S. Department of Veteran Affairs;

(vi) A qualified non-governmental research entity identified in the guidelines issued by the federal National Institutes of Health for center support grants; or

(vii) A study or investigation conducted by the U.S. Department of Veteran Affairs, the U.S. Department of Defense, or the U.S. Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of U.S. Department of Health and Human Services determines:

Is comparable to the system of peer review of studies and investigations used by the federal National Institutes of Health; and

Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(B) The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration; or

(C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

then your participation will be covered to the extent of routine patient costs including all items and services consistent with the coverage typically covered for a qualified individual who is not enrolled in an approved clinical trial. Routine patient costs do not include:

(i) The investigational item, device or service itself;

(ii) Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

(iii) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Related Exclusions

Except as described otherwise in this Section 3.12, this *agreement* does NOT cover services, treatments, procedures, facilities, equipment, drugs, devices, supplies, or services that are *experimental/investigational*.

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

3.13 Hemodialysis Services Inpatient

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

Outpatient

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

In Your Home

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

Related Exclusions

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

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

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

3.14 Hemophilia Services

Outpatient/In a Doctor's Office

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

-

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

For information about coverage for prescription drugs, including, but not limited to clotting factor drugs, see Section 3.29 - Prescription Drugs.

3.15 Home Health Care In Your Home

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

We cover the following *medically necessary* services:
- nurse services;
- services of a home health aide;
- visits from a social worker; and
- physical and occupational therapy.

For information about *doctor* home and office visits see Section 3.18 - House Calls and Section 3.24 - Office Visits. For home care equipment and supplies, see Section 3.23 - Medical Equipment, Medical Supplies, and Prosthetic Devices. For radiation therapy or chemotherapy services, see Section 3.32 - Radiation Therapy/Chemotherapy Services. For prescription drugs, see Section 3.29 - Prescription Drugs.

Related Exclusions

This *agreement* does NOT cover:
- any homemaking, companion, or chronic (custodial) care services;
- the services of a personal care attendant;
- *charges* for private duty nursing when primary duties are limited to bathing, feeding, exercising, homemaking, giving oral prescription drugs or acting as a companion; OR
- services of a private nurse who is a *member* of your home or the cost of any care provided by one of your relatives (by blood, marriage, or adoption).

3.16 Hospice Care

Inpatient

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

Related Exclusions

This *agreement* does NOT cover custodial care, respite care, day care, or care in a facility that is not approved by us. See Section 4.6 - Services Provided by Facilities We Have Not Approved.

In Your Home

If you have a terminal illness and you agree with your *doctor* not to continue with a curative

treatment program, we cover some hospice care services provided by a hospice care *program,* such as*:*

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

For information about *doctor* home and office visits, see Section 3.18 - House Calls and Section 3.24 - Office Visits. For hospice care equipment and supplies, see Section 3.23 - Medical Equipment, Medical Supplies, and Prosthetic Devices. For prescription drugs, see Section 3.29 - Prescription Drugs.

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

3.17 Hospital Services

Inpatient

Semi-Private Room Charges/Days of Hospital Coverage

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

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

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

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

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

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

Related Exclusions

This *agreement* does NOT cover:

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

3.18 House Calls

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

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

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

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

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

3.20 Infertility Services Inpatient/Outpatient/In a Doctor's Office

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

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

Infertility services, including prescription drug coverage, are covered up to the *benefit limit* and *level of coverage* shown in the Summary of Benefits. Infertility prescription drug coverage is based on the route of administration and site of service. See Section 3.29 - Prescription Drugs for details. See the Summary of Pharmacy Benefits for *benefit limits* and *level of coverage*.

Related Exclusions

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

3.21 Infusion Therapy

Inpatient

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

Outpatient

If you receive infusion therapy services in a *hospital's outpatient* unit, we cover the use of the treatment room, related supplies, and solutions. For prescription drug coverage, see Section 3.29 - Prescription Drugs.

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

In a Doctor's Office

If you receive infusion therapy services in a *doctor's* office, we cover the related supplies and solutions. For prescription drug coverage, see Section 3.29 - Prescription drugs.

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

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

For information about *doctor* home and office visits see Section 3.18 - House Calls and Section 3.24 - Office Visits. For home care equipment and supplies, see Section 3.23 - Medical Equipment, Medical Supplies, and Prosthetic Devices. For radiation therapy or chemotherapy services, see Section 3.32 - Radiation Therapy/Chemotherapy Services. For prescription drugs, see Section 3.29 - Prescription Drugs.

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

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

For coverage of specific services, see Section 3.8 - Diagnostic Imaging, Lab, and Machine Tests, 3.24 - Office Visits, 3.21 Infusion Therapy, and 3.29 - Prescription Drugs.

3.23 Medical Equipment, Medical Supplies, Enteral Formula or Food, and Prosthetic Devices
We cover *medically necessary durable medical equipment*, *medical supplies,* and *prosthetic devices* that meet the minimum specifications.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This *agreement* provides benefits for mastectomy-related prosthetics in accordance with the Women's Health and Cancer Rights Act of 1998 and Rhode Island General Laws 27-20-29 et seq. See Section 3.37 Surgery Services - Mastectomy.

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

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

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

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

This *agreement* does NOT cover pillows or batteries, except when used for the operation of a covered prosthetic device, or items whose sole function is to improve the quality of life or mental well being. See Section 4.28 for a list of personal appearance and service items NOT covered by this *agreement.*

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

Enteral formulas or food (enteral nutrition)
Enteral formula or food is nutrition that is absorbed through the intestinal tract, whether delivered through a tube for feeding or taken orally. The *level of coverage* differs depending on whether the enteral formula or food is the sole source of nutrition delivered through a feeding tube or taken orally.

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

In accordance with Rhode Island General Law §27-20-56, this *agreement* covers *medically necessary* enteral formula taken orally for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, chronic intestinal pseudo obstruction, and inherited diseases of amino acids and organic acids. Enteral formula is covered when a *doctor* has issued a written order and must be for home use. Also, food products modified to be low protein are covered for the treatment of inherited diseases of amino acids and organic acids. *Preauthorization* is recommended.

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

Related Exclusions

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

Hair Prosthetics (Wigs)

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

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

Related Exclusions

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

Hearing Aid

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

We will provide coverage up to the *maximum benefit*. You are responsible for paying the full amount due to the *provider.* If the full amount due to the *provider* is more than the *maximum benefit*, you are responsible for paying any difference. See Section 7.1 - How to File a Claim. We

will reimburse the lesser of the *provider's charges* or the *maximum benefit* amount shown in the Summary of Medical Benefits.

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

3.24 Office Visits In a Doctor's Office

Our *allowance* for an office visit includes *medical supplies* provided as part of the office visit. See the Summary of Medical Benefits for *benefit limits* and *level of coverage* for each service in this section.

When physician services are rendered in a *doctor's* office, other than an office visit examination, the *level of coverage* is based on the type of service being rendered. For surgical services (including but not limited to sutures, fracture care, and other surgical procedures) see Section 3.37 Surgery Services. For diagnostic imaging, lab and machine tests, see Section 3.8.

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

Asthma Education

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

Other asthma related *covered health care services* including, but not limited to, office visits rendered by a *provider* (other than a certified asthma educator), medical equipment and supplies, and prescription drugs are subject to the benefit rules that apply to the specific services. For information about office visits, see Section 3.24 - Office Visits. For medical equipment and supplies, see Section 3.23 - Medical Equipment, Medical Supplies, and Prosthetic Devices. For prescription drugs, see Section 3.29 - Prescription Drugs. See the Summary of Benefits for *benefit limits* and *level of coverage* for each section.

Diabetes Education

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

Hospital Based Clinic Visits

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

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

Office Visits (other than Pediatric Office Visits)
We cover other *medically necessary* office visits, including visits to *urgent care centers,* provided they are reasonable in number and in the scope of the services rendered for the following:

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

See the Summary of Medical Benefits for *benefit limits* and *level of coverage*. For prescription drug coverage, see Section 3.29 - Prescription Drugs. For d*octor* visits to your home, see Section 3.18 - House Calls.

Obstetrical or Gynecological Care
You do not need *preauthorization* from us or from any other person (including a *personal physician*) in order to obtain access to obstetrical or gynecological care from a *network doctor* who specializes in obstetrics or gynecology. Your *doctor,* however, may be required to comply with certain procedures, including obtaining *preauthorization* for certain services. For a list of *network* physicians who specialize in obstetrics or gynecology, contact our Customer Service Department.

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

Allogenic bone marrow transplant *covered health care services* include medical and surgical services for the matching participant donor and the recipient. However, Human Leukocyte Antigen testing is covered as indicated in the Summary of Benefits, subject to certain conditions. For details see Section 3.19 - Human Leukocyte Antigen Testing.

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

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

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

- obtaining donated organs (including removal from a cadaver);

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

The *level of coverage* for transplant services for the recipient and eligible donor is based on the type of service. For information about office visits see Section 3.24 - Office Visits. For surgical procedures see Section 3.37 - Surgery Services. For lab, radiology, and machine tests see Section 3.8 - Diagnostic Imaging, Lab, and Machine Tests. For prescription drugs, see Section 3.29 - Prescription Drugs. See the Summary of Benefits for *benefit limits* and *level of coverage* for each type of service.

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

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

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

Outpatient/In a Doctor's/Therapist's Office
Physical or occupational therapy services received in a *doctor's*/therapist's office are covered. See the Summary of Benefits for benefit limits and level of coverage.

In Your Home
This *agreement* does NOT cover physical or occupational therapy services received in your home unless received through a home care *program*. See Section 3.15 - Home Health Care.

Related Exclusions

This *agreement* does NOT cover:

- services rendered by a massage therapist.
- hippotherapy.

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

3.27 Podiatrist Services

This *agreement* covers office visits to the podiatrist.

Related Exclusions

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

This *agreement* does NOT cover the treatment of flat feet unless the treatment is surgical. Corrective or orthopedic shoes and orthotic devices used in connection with footwear are NOT covered unless for the treatment of diabetes. See Section 3.7 - Diabetic Equipment/ Supplies.

3.28 Pregnancy Services and Nursery Care

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

Under federal law, individual health plans and health insurance issuers offering individual health insurance 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 48 hours following a vaginal delivery, or less than 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 health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Inpatient

In accordance with Rhode Island General Law §27-20-17.1, this *agreement* covers a minimum *inpatient hospital* stay of forty-eight (48) hours from the time of a vaginal delivery and ninety-six (96) hours from the time of a cesarean delivery. If you don't deliver your baby at a hospital, these time periods begin at the time you are admitted to the hospital.

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

Any decision to shorten these stays shall be made by the attending physician in consultation with and upon *agreement* with you. In those instances where you and your infant participate in an early discharge, you will be eligible for:
- Up to two (2) home care visits by a skilled, specially trained registered nurse for you and/or your infant, (any additional visits must be reviewed for medical necessity); and
- A pediatric office visit within twenty-four (24) hours after discharge.

See Section 3.18 - House Calls and Section 3.24 - Office Visits for coverage of home and office visits.

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

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

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

The first office visit to diagnose pregnancy is not included in prenatal services. Office visits to an obstetrician or midwife that are not related to pregnancy are not included in prenatal services. Both are covered as an office visit. See Section 3.24 - Office Visits.

3.29 Prescription Drugs and Diabetic Equipment/Supplies

Definitions
The following definitions apply to this Section 3.29:

DISPENSING GUIDELINES means:
- the prescription order or refill must be limited to the quantities authorized by your *doctor* not to exceed the quantity listed in the Summary of Pharmacy Benefits;
- the prescription must be *medically necessary*, consistent with the *doctor's* diagnosis, ordered by a *doctor* whose license allows him or her to order it, filled at a pharmacy whose license allows such a prescription to be filled, and filled according to state and federal laws;
- the prescription must consist of *legend drugs* that require a *doctor's* prescription under law or compound medications made up of at least one *legend drug* requiring a *doctor's* prescription under law; and

- the prescription must be dispensed at the proper place of service as determined by our Pharmacy and Therapeutics Committee. For example, certain prescription drugs may only be covered when obtained from a *provider*.

Quantity limits may apply. Some prescription drugs are subject to additional quantity limits based on criteria that we have developed. You may obtain a current list of prescription drugs that have been assigned maximum quantity levels for dispensing by visiting our Web site at nhpri.org or calling our Customer Service Department at (401) 459-6000 or 1-800-963-1001.

FORMULARY means the prescription drugs and dosage forms covered under this *agreement.* Some prescription drugs are not in the *formulary*. If a prescription drug is not in our *formulary*, then it is not covered under this *agreement*. A committee of local physicians and pharmacists, set up by us, develop the prescription drug *formulary* listing which is subject to periodic review and is subject to change. The committee decides the tier placement of drugs in the *formulary*, which determines the amount you will pay. To obtain coverage information for a specific prescription drug or to get a copy of the most current *formulary* listing, visit our Web site at nhpri.org. Or, you may call our Customer Service Department at (401) 459-6000 or 1-800-963-1001 for information.

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

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

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

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

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

SITE OF SERVICE means, for the purposes of this a*greement*, the three types of pharmacies which include:

- retail pharmacies,
- specialty pharmacies, and
- mail order pharmacy.

SPECIALTY PRESCRIPTION DRUG is a type of prescription drug in our *formulary* that generally is identified by, but not limited to, features such as:

- being produced by DNA technology,
- treats chronic or long term disease,
- requires customized clinical monitoring and patient support, and
- needs special handling.

Generally, specialty pharmacies dispense *specialty prescription drugs*. Contact Customer Service for further details and information about *specialty prescription drugs* and specialty pharmacies. For the purposes of this *agreement*, we have designated certain prescribed prescription drugs to be *specialty prescription drugs* in our *formulary.* To obtain coverage information for any specific *specialty prescription drug* or to obtain a copy of the most current *formulary* listing, visit our Web site at nhpri.org Or, you may call our Customer Service Department at (401) 459-6000 or 1-800-963-1001.

TYPE OF SERVICE means, for the purposes of this *agreement*, the two kinds of prescription drugs which are defined as:

- generic, preferred brand name, and non-preferred brand name prescription drugs; and
- *specialty prescription drugs.*

Overview

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

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

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

Introduction

This section provides coverage information for prescription drugs in our *formulary* and diabetic equipment and supplies that are bought at a pharmacy. The prescription drug must be identified as covered under this *agreement* in our *formulary* and dispensed per our *dispensing guidelines* in order to be covered.

Generic, preferred brand name, and non-preferred brand name prescription drugs may be dispensed at a retail pharmacy, a specialty pharmacy, a mail order pharmacy, or by a provider other than a pharmacy. *Specialty prescription drugs* must be dispensed at a specialty pharmacy or a *non-network pharmacy.* If a professional provider dispenses a *specialty prescription drug,* it is not separately reimbursed unless obtained from a specialty pharmacy. The administration of the *specialty prescription drug* is covered.

For information about the administration of *specialty prescription drugs*, see Section 3.2 - Behavioral Health, Section 3.14 - Hemophilia Services, Section 3.15 - Home Health Care, Section 3.20 - Infertility Services, Section 3.21 - Infusion Therapy, Section 3.24 - Office Visits, and Section 3.32 - Chemotherapy Services.

If you are dispensed a *specialty prescription drug* from a Rhode Island *network provider,* the charge for the *specialty prescription drug* is not reimbursed and the Rhode Island *network provider* may not seek reimbursement from you. If you are dispensed a *specialty prescription drug* from a *non-network provider* the charge for the *specialty prescription drug* is not reimbursed. You are liable to pay the charge for the *specialty prescription drug*.

Prescription drugs are reimbursed based on the *type of service* and the *site of service*. See the Summary of Pharmacy Benefits for *benefit limits* and *level of coverage*.

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

Four-Tier Copayment Structure

This prescription drug plan *formulary* has a four-tiered *copayment* structure.

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

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

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

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

Our *formulary* lists generic, preferred brand name, and non-preferred brand name prescription drugs and *specialty prescription drugs* covered under this *agreement.* We decide which tier a drug will be placed into for *copayment* purposes. To check the tier placement of a prescription drug or to obtain a copy of the most current *formulary* listing, visit our Web site at nhpri.org. Or, you may call our Customer Service Department at (401) 459-6000 or 1-800-963-1001.

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

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

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

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

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

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

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

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

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

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

- By fax, submit the form to PerformRx at 1-888-836-0730;
- By phone, contact PerformRx at 1-800-294-5979;

- By mail, send the completed form to:

  Perform RX
  200 Stevens Drive
  Philadelphia, PA 19113

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

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

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

If you have not obtained *prescription drug preauthorization* before you pick up the prescription drug from the pharmacy for the first time, you can ask us to consider reimbursement later. To do this, you must follow the *prescription drug preauthorization* process described above and submit your request for review, along with a copy of your receipt, within fifteen (15) days of picking up the prescription. If our clinical guidelines are met for the prescription drug, we will approve your claim to be reimbursed retroactively less the applicable *copayment* or *deductible*.

To obtain a list of the brand name prescription drugs and *specialty prescription drugs* that require *prescription drug preauthorization*, visit our Web site at nhpri.org or call our Customer Service Department at (401) 459-6000 or 1-800-963-1001.

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

How to Obtain Dose Optimization
Dose optimization is the most effective dose and measured quantity of a generic, preferred brand name, and non-preferred brand name prescription drug to be taken at one time. Under this *agreement*, certain generic, preferred brand name, and non-preferred brand name prescription drugs may NOT be covered if you are taking multiple daily doses of a prescription drug that is available to be taken once per day at a higher dose. To obtain a list of the prescription drugs subject to dose optimization, visit our Web Site at nhpri.org Or, you may call our Customer Service Department at (401) 459-6000 or 1-800-963-1001.

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

If your prescribing provider deems it *medically necessary* that you continue to take multiple daily doses of a lower strength generic, preferred brand name, or non-preferred brand name prescription drug, *prescription drug preauthorization* is required and must be obtained before we provide coverage. To request *prescription drug preauthorization,* the prescribing *provider* must complete and submit a dose optimization authorization form. Coverage for multiple daily doses of a lower strength generic, preferred brand name, or non-preferred brand name prescription drug will only be approved when the dose optimization guidelines are met.
The prescribing *provider* may obtain a form by visiting our Web site at nhpri.org or calling the Physician and Provider Service Center. Requests may be submitted in one of the following ways:

- By fax, submit the form to PerformRx at 1-888-836-0730;
- By phone, contact PerformRx at 1-800-294-5979;

- By mail, send the completed form to:
  Perform RX
  200 Stevens Drive
  Philadelphia, PA 19113

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

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

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

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

Co-payment reduction
Certain prescription drugs will have a reduced *copayment* for members with diabetes, asthma, and chronic obstructive pulmonary disease (COPD). To obtain a specific list of the included

drugs, call our Customer Service Department or visit our website at www.nhpri.org

Covered Over-the-Counter (OTC) Drugs

In accordance with PPACA, certain preventive over-the-counter (OTC) drugs when prescribed by a physician are covered. To obtain a specific list of the OTC drugs that are covered, call our Customer Service Department or visit our website at www.nhpri.org

Related Exclusions

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

- biological products for allergen immunotherapy;
- biological products for vaccinations;
- blood fractions;
- compound prescription drugs that are not made up of at least one *legend drug;*
- prescription drugs prescribed or dispensed outside of our *dispensing guidelines*;
- prescription drugs indicated as being not covered on our *formulary*;
- prescription drugs purchased in excess of the stated quantity limits;
- 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);
- drugs you take or have given to you while you are a patient in a *hospital,* rest home, sanitarium, nursing home, home care *program*, or other institution that provides prescription drugs as part of its services or which operates its own facility for dispensing prescription drugs;
- non-medical substances (regardless of the reason prescribed, the intended use, or medical necessity);
- off-label use of prescription drugs (except as described in Section 3.12 *Experimental/Investigational* Services);
- over-the-counter (OTC) drugs even if prescribed, unless specifically listed as a *covered health care service* in this *agreement* (e.g., such as OTC nicotine replacement therapy in accordance with Rhode Island General Law 27-20-53 and PPACA or as part of our OTC Options Program;
- prescribed weight-loss drugs;
- OTC drugs designated as covered under this *agreement* for which you do not have a written prescription from your physician
- replacement prescription drug products resulting from a lost, stolen, broken or destroyed prescription order or refill;
- support garments and other durable medical equipment;
- therapeutic devices and appliances, including hypodermic needles and syringes (except when used to administer insulin);
- sildenafil citrate (Viagra) or any therapeutic equivalents; OR
- Vitamins, unless specifically listed as a

covered health care service in this *agreement*.

We will NOT cover a prescription drug refill if the refill is:

- greater than the refill number authorized by your *doctor;*

- greater than the twelve (12) refills we authorize;
- limited by law; or
- re-filled more than a year from the date of the original prescription.

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

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

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

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

Certain prescribed prescription drugs that have an over-the-counter equivalent (OTC) are NOT covered under this *agreement.* To obtain the list of OTC prescription drugs visit our Web site at nhpri.org or contact our Customer Service Department at (401) 459-6000 or 1-800-963-1001.

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

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

Outpatient/In Your Doctor's Office/In Your Home
Generic, preferred brand name, or non-preferred brand name prescription drugs are covered at different benefit levels depending upon the route of administration. Our *allowance* for services rendered by the facilities, agencies, and professional *providers* may include the cost of the prescription drugs administered and/or dispensed. We will determine coverage based upon the route of administration that is customary and least invasive method to treat the condition. There are several ways to administer drugs into the body including:
- inhalation (into the lungs, usually through the mouth);
- intramuscular (injected into a muscle);
- intrathecal (injected into the space around the spinal cord);
- intravenous/infused/intra-arterial (into a vein or artery);

- nasal (sprayed into the nose);
- ocular (instilled in the eye);
- oral (by mouth);
- rectal or vaginal (inserted into the rectum or vagina);
- subcutaneous (injected beneath the skin);
- sublingual (under the tongue);
- topical (applied to the skin); OR
- transdermal (delivered through the skin by a patch).

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

Injected Generic, Preferred Brand Name, or Non-Preferred Brand Name Prescription Drugs We use the term injected to include prescription drugs approved by us given by intra muscular or subcutaneous injection or in the case of a body cavity by instillation. See the Summary of Medical Benefits for *benefit limits* and *level of coverage*. See Section 3.30 Prevention and Early Detection Services for immunization and vaccination coverage information.

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

Related Exclusions

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

If you are dispensed a *specialty prescription drug* from a Rhode Island *network provider,* the charge for the *specialty prescription drug* is not reimbursed and the Rhode Island *network provider* may not seek reimbursement from you. If you are dispensed a *specialty prescription drug* from a *non-network provider* the charge for the *specialty prescription drug* is not reimbursed and you are liable to pay the charge for the *specialty prescription drug*. Please contact our Customer Service Department at (401) 459-6000 or 1-800-963-1001 for further details.

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

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

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

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

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

The *level of coverage* for early detection services, preventive *care services*, and adult and pediatric immunizations/vaccination is indicated in the Summary of Medical Benefits

One pap smear annually is covered at the *level of coverage* for early detection services as shown in the Summary of Benefits. The *level of coverage* for your second and subsequent pap smear is covered as a lab test. For information about lab, radiology, and machine tests see Section 3.8 - Diagnostic Imaging, Lab, and Machine Tests.

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

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

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

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

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

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

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

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

3.31 Private Duty Nursing Services In Your Home

We cover private duty nursing services received in your home when *medically necessary,* ordered by a physician, and performed by a certified home health care agency. Private duty nursing services are covered when the patient requires continuous skilled nursing observation and intervention.

Related Exclusions

This agreement does NOT cover:

- services of a nurse's aide;
- services of a private duty nurse when the primary duties are limited to bathing, feeding, exercising, homemaking, giving oral medications or acting as companion or sitter;
- services of a private duty nurse who is a member of your household or the cost of any care provided by one of your relatives (by blood, marriage or adoption);
- maintenance care when the condition has stabilized (including routine ostomy care or tube feeding administration) or if the anticipated need is indefinite;
- care for a person without an available caregiver in the home (twenty four (24) hour private duty nursing is not covered);
- respite care (e.g., care during a caregiver vacation) or private duty nursing so that the caregiver may attend work or school;
- services of a private duty nurse after the caregiver or patient have demonstrated the ability to carry out the plan of care;
- services of a private duty nurse provided outside the home (e.g., school, nursing facility or assisted living facility);
- services of a private duty nurse that are duplication or overlap of services (e.g., when a person is receiving hospice care services or for the same hours of a skilled nursing home care visit.); or
- services of a private duty nurse that are for observation only.

3.32 Radiation Therapy/Chemotherapy Services

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

Inpatient

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

Outpatient/In a Doctor's Office

Radiation Therapy

We cover *hospital* and *doctor* services for outpatient radiation therapy. Radiation physics, dosimetry services, treatment devices, and *hospital services* are included in radiation treatment planning and therapy and are covered as part of our *allowance* for radiation therapy.

Chemotherapy Services
This *agreement* covers the *doctor's* administration fee and associated *hospital* supplies. For information about anti-neoplastic (chemotherapy) prescription drug coverage, see Section 3.29 - Prescription Drugs.

In Your Home

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

Chemotherapy Services
This *agreement* covers the *doctor's* administration fee. For information about anti-neoplastic (chemotherapy) prescription drug coverage, see Section 3.29 - Prescription Drugs.

3.33 Respiratory Therapy

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

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

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

In Your Home
We cover durable medical equipment and oxygen at the same *benefit limit* and *level of coverage* as stated in the Summary of Medical Benefits for medical equipment and medical supplies. See Section 3.23 - Medical Equipment, Medical Supplies, and Prosthetic Devices for details.

Related Exclusions
This *agreement* does NOT cover respiratory therapy services when received in your home, unless received through a home care *program* or hospice care *program*. See Section 3.15 - Home Health Care and Section 3.16 - Hospice Care.

3.34 Skilled Care in a Nursing Facility

Care in a skilled nursing facility is covered if:

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

Related Exclusions
This *agreement* does NOT cover custodial care, respite care, day care, or care in a facility that is not approved by us. See Section 4.6 - Services Provided by Facilities We Have Not Approved.

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

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

Related Exclusions

This *agreement* does not provide coverage for:

- nicotine replacement therapy without a prescription;
- nicotine replacement therapy when bought from a *provider* other than a pharmacy; and
- nicotine replacement therapy and smoking cessation prescription drugs when bought from a mail order pharmacy.

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

Inpatient

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

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

We will cover speech therapy *rehabilitative services* when received from a registered therapist as part of a formal treatment plan for:

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

Speech therapy services must relate to:

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

Some services rendered by a speech therapist are classified as diagnostic tests. See Section 3.8 - Diagnostic Imaging, Lab, and Machine Tests and the Summary of Medical Benefits for *benefit limits* and *level of coverage*.

In Your Home

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

Related Exclusions

This *agreement* does NOT cover these services if another entity or agency which provides services for the health of school children or children with disabilities is responsible for such

services under state or federal laws. (See generally, Title 16, Chapters 21, 24, 25 and 26 of the Rhode Island General Laws. See also applicable regulations about health of school children and the special education of children with disabilities or similar rules set forth by federal law.)

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

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

3.37 Surgery Services

General Surgery

If you have an operation to treat a disease or injury, we cover it as long as the following conditions apply:
- the operation is not *experimental/investigational* or cosmetic in nature;
- the operation is being performed at the appropriate place of service; AND
- the *doctor* is licensed to perform the surgery.

In a Doctor's Office

This *plan* covers surgical procedures performed in a *doctor's* office up to the level of coverage indicated in the Summary of Benefits.

When other physician services are rendered in the *doctor's* office, other than the surgical procedure, the *level of coverage* is based on the type of service being rendered. For office visits see Section 3.24 Office Visits. For Diagnostic Imaging, Lab, and Machine tests see Section 3.8. See the Summary of Benefits for *benefit limits* and *level of coverage* for each section.

Multiple Surgeries

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

If More Than One Surgeon Operates

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

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

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

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

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: [insert deductibles and coinsurance applicable to these benefits].

Surgery to Treat Functional Deformity or Impairment
Reconstructive surgery and procedures are covered under this *agreement* when performed to correct:
- a functional deformity due to a previous therapeutic process; or
- a documented functional impairment caused by trauma, congenital anomaly or disease.

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

We cover some surgical procedures to treat functional impairments. We cover those procedures listed below to treat functional impairments when *medically necessary:*
- Abdominal wall surgery including Panniculectomy (other than an abdominoplasty);
- Blepharoplasty and Ptosis Repair;
- Gastric Bypass or Gastric Banding;
- Nasal Reconstruction and Septorhinoplasty;
- Orthognathic surgery including Mandibular and Maxillary Osteotomy;
- Reduction Mammoplasty;

- Removal of Breast Implants;
- Removal or Treatment of Proliferative Vascular Lesions and Hemangiomas; or
- Treatment of Varicose Veins.

We may need to review the following medical documentation to be able to make a decision about coverage for the above listed procedures:
- history and physical;
- preoperative diagnostic studies;
- previously tried conservative medical therapy and photographs; or
- other medical records.

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

Related Exclusions

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

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

This *agreement* does NOT cover cosmetic procedures. Cosmetic procedures are performed primarily:
- to refine or reshape body structures that are not functionally impaired;
- to improve appearance or self-esteem; or
- for other psychological, psychiatric or emotional reasons.

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

The following procedures are NOT covered under this *agreement*:
- Abdominoplasty;
- Cervicoplasty;
- Chemical exfoliations, peels, abrasions (or dermabrasions or planing for acne, scarring, wrinkling, sun damage or other benign conditions);
- Correction of variations in normal anatomy including augmentation mammoplasty, mastopexy, and correction of congenital breast asymmetry;
- Dermabrasion;
- Ear Piercing or repair of a torn earlobe;
- Excision of Excess Skin or Subcutaneous Tissue (except Panniculectomy as listed above);
- Genioplasty;
- Gynecomastia surgery, including but not limited to mastectomy and reduction mammoplasty;
- Hair Transplants;
- Hair Removal (including electrolysis epilation);
- Inverted nipple surgery;
- Laser treatment for acne and acne scars;
- Osteoplasty - Facial Bone Reduction;

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- Otoplasty;
- Procedures to correct visual acuity including, but not limited to, cornea surgery or lens implants;
- Removal of Asymptomatic Benign Skin Lesions;
- Repeated cauterizations or electrofulguration methods used to remove growths on the skin;
- Rhinoplasty;
- Rhytidectomy;
- Scar Revision, regardless of symptoms;
- Sclerotherapy for Spider Veins;
- Subcutaneous Injection of Filling Material;
- Suction assisted Lipectomy;
- Tattooing or Tattoo Removal (except tattooing of the nipple/areola related to a mastectomy); or
- Testicular prosthesis surgery.

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

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

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

Other than the pre-operative office visit, this *agreement* covers office visits or office consultations to anesthesiologists as an office visit. See Section 3.24 - Office Visits.

Anesthesia services when rendered at a *hospital* or *free-standing ambulatory surgi-center* in connection with a dental service are covered when the use of the *hospital* or *free-standing ambulatory surgi-center* is *medically necessary* and the setting in which the service received is determined to be appropriate. *Preauthorization* is recommended for this service. The dental services will remain non-covered. See Section 4.18.

Related Exclusions
This *agreement* does NOT cover:
- local anesthesia provided by an anesthesiologist or anesthesia administered by a surgeon, assistant surgeon, or obstetrician;
- services of a standby anesthesiologist; and
- patient controlled analgesia, also known as pain management.

3.38 Vision Care Services Eye Examinations

We cover one routine eye exam per *contract year* if an optometrist or ophthalmologist performs the examination. We cover *medically necessary* eye examinations.

3.39 Pediatric Vision Services and Supplies

Important things you should keep in mind about these benefits:
Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care or treatment of a covered condition and meet generally accepted protocols.

Benefit Description	**You Pay**	
Diagnostic	**Standard Option**	**High Option**
Eye exam: covered in full every calendar year. Includes dilation, if professionally indicated. 92002/92004 New patient exams 92012/92014 Established patient exams S0620 Routine ophthalmologic exam w/refraction - new patient S0621 Routine ophthalmologic exam w/refraction - established patient	In-Network: Nothing Out-of-Network: All charges	In-Network: Nothing Out-of-Network: Expenses in excess of the fee schedule allowance of $tbd
Eyewear	**Standard Option**	**High Option**
You may choose prescription glasses or contacts.		
Lenses: one pair covered in full every calendar year. V2100-2199 Single Vision V2200-2299 Conventional (Lined) Bifocal V2300-2399 Conventional (Lined) Trifocal V2121, V2221, V2321 Lenticular Note: Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses. Note: Polycarbonate lenses are covered in full for children, monocular patients and patients with prescriptions > +/- 6.00 diopters. Note: All lenses include scratch resistant coating with	In-Network: Nothing Out-of-Network: All charges	In-Network: Nothing Out-of-Network: Expenses in excess of fee schedule allowance of: $tbd single vision $tbd lined bifocal $tbd lined trifocal $tbd lenticular

no additional copayment. There may be an additional charge at Walmart and Sam's Club		
Frame: High Option: covered once every calendar year. Standard Option: covered once every other calendar year. V2020 Frame *Note: Additional discounts are available from participating providers except Walmart and Sam's Club. Note: Your eyewear will be delivered to your provider from the TBD laboratory generally within two to five business days. More delivery time may be needed when out-of-stock frames, AR (anti-reflective) Coating, specialized prescriptions or a non-collection frame is selected. Note: "Collection" frames with retail values up to $225 are available at no cost at most participating independent providers. Retail chain providers typically do not display the "Collection," but are required to maintain a comparable selection of frames that are covered in full.	In-Network: Collection Frame: Nothing Non-Collection Frame: Expenses in excess of a $tbd allowance. Additionally, a tbd% discount applies to any amount over $tbd* Out-of-Network: All charges	In-Network: Collection Frame: Nothing Non-Collection Frame: Expenses in excess of a $tbd allowance. Additionally, a tbd% discount applies to any amount over $tbd* Out-of-Network: Expenses in excess of fee schedule allowance of $tbd
Contact Lenses	**Standard Option**	**High Option**
Contact Lenses: covered once every calendar year – in lieu of eyeglasses. V2500-V2599 Contact Lenses Note: In some instances, participating providers may charge separately for the evaluation, fitting, or follow-up care relating to contact lenses. Should this occur and the value of the Contact Lenses received is less than the allowance, you may submit a claim for the remaining balance (the combined reimbursement will not exceed the total allowance). *Note: Additional discounts are available from participating providers except Walmart and Sam's Club.	In-Network: Expenses in excess of a $tbd allowance (may be applied toward the cost of evaluation, materials, fitting and follow-up care). Additionally, a tbd% discount applies to any amount over $tbd.* Expenses in excess of $tbd for medically necessary contact lenses.** Out-of-Network: All charges	In-Network: Expenses in excess of a $tbd allowance (may be applied toward the cost of evaluation, materials, fitting and follow-up care). Additionally, a tbd% discount applies to any amount over $tbd.* Expenses in excess of $tbd for medically necessary contact lenses.** Out-of-Network: Expenses in excess of fee schedule allowance of: $tbd elective contact lenses $tbd medically necessary contact lenses

****Note: Pre-authorization is required.**		
Other Vision Services	**Standard Option**	**High Option**
Optional Lenses and Treatments	In Network Only	In Network Only
Ultraviolet Protective Coating	$tbd	$tbd
Polycarbonate Lenses (if not	$tbd	$tbd
child, monocular or	$tbd	$tbd
prescription >+/-6.00 diopters)	$tbd	$tbd
Blended Segment Lenses		
Intermediate Vision Lenses	$tbd	$tbd
Standard Progressives	$tbd	$tbd
Premium Progressives (Varilux®,	$tbd	$tbd
etc.)	$tbd	$tbd
Photochromic Glass Lenses		
Plastic Photosensitive Lenses	$tbd	$tbd
(Transitions®)	$tbd	$tbd
Polarized Lenses		
Standard Anti-Reflective (AR)	$tbd	$tbd
Coating	$tbd	$tbd
Premium AR Coating		
Ultra AR Coating	$tbd	$tbd
Hi-Index Lenses	$tbd	$tbd
	$tbd	$tbd
Extra Discounts and Savings	**Standard Option**	**High Option**
Prescription glasses • Optional Lens Treatments (only available from TBD providers) - **Progressive Lens Options:** Members may receive a discount on additional progressive lens options:		
Select Progressive Lenses	**$tbd**	**$tbd**
Ultra Progressive Lenses	**$tbd**	**$tbd**

3.40 Habilitative Services

Habilitative services include physical, occupational and speech/language therapies. Services are covered in the following instances:

- Improving speed to recovery;
- Improving long-term functional and health status and improving the likelihood of independent living and high quality of life;
- Reducing the likelihood of relapse and rehospitalization;
- Halting or slowing the progression of primary and secondary disabilities (maintain functioning and prevent further deterioration);

Physical and Occupational Therapy

Physical and occupational therapy is covered only when:

- a *program* is implemented to achieve the highest level of independent functioning in the most timely manner possible;

- physical or occupational therapy is received from a licensed physical or occupational therapist;

- physical or occupational therapy is ordered by a *doctor;*

- the therapy will result in significant, sustained measurable functional or anatomical improvement of your condition; and

- such improvement will not diminish with the removal of the therapeutic agent or environment.

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

Outpatient/In a Doctor's/Therapist's Office
Physical or occupational therapy services received in a *doctor's*/therapist's office are covered. See the Summary of Benefits for benefit limits and level of coverage.

In Your Home
This *agreement* does NOT cover physical or occupational therapy services received in your home unless received through a home care *program*. See Section 3.15 - Home Health Care.covered

Speech Therapy

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

Inpatient

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

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

- improvement of speech or communication function or

- an acute exacerbation of chronic disease.

Speech therapy services must relate to:

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

Some services rendered by a speech therapist are classified as diagnostic tests. See Section 3.8 - Diagnostic Imaging, Lab, and Machine Tests and the Summary of Medical Benefits for *benefit limits* and *level of coverage*.

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

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

This *agreement* does not cover:

- *maintenance services;*
- educational classes and services for impairments that are self-correcting; or
- services related to food aversion or texture disorders.

This *agreement* does not cover language and communication *developmental services* including, but not limited to, the following:

- psychosocial speech delay;
- expressive language delay;
- behavioral problems;
- attention disorders;
- conceptual handicap;
- mental retardation;
- autism;
- developmental delay; or

stammering and stuttering

4.0 HEALTH CARE SERVICES NOT COVERED UNDER THIS AGREEMENT

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

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

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

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

If a service or category of service is not listed as covered, it is not covered under this *agreement.*

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

4.1 Services Not Medically Necessary

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

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

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

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

4.2 Services Not Listed in Section 3.0

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

4.3 Services Covered by the Government

This *agreement* does NOT cover medical expenses for any condition, illness, or disease which should be covered by the United States government or any of its agencies, Medicare, any

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

4.4 Services and Supplies Mandated by Laws in Other States

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

4.5 Services Provided By College/School Health Facilities

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

4.6 Services Provided By Facilities We Have Not Approved

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

4.7 Services Performed by Excluded Providers

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

4.8 Services Performed by People/Facilities Who Are Not Legally Qualified or Licensed

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

4.9 Services Performed by Naturopaths and Homeopaths

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

4.10 Services If You Leave the Hospital or If You Are Discharged Late

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

4.11 Benefits Available from Other Sources

This *agreement* does NOT cover the cost of *covered health care services* provided to you when there is no charge to you or there would have been no charge to you absent this

agreement. This *agreement* does NOT cover health care services when you can recover all or a portion of the cost of such services through a federal, state, county, or municipal law or through legal action. This is true even if you choose not to assert your rights under these laws or if you fail to assert your rights under these laws.

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

4.12 Blood Services

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

4.13 Charges for Administrative Services

This *agreement* does NOT cover:

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

4.14 Christian Scientist Practitioners

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

4.15 Clerical Errors

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

4.16 Consultations - Telephone

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

4.17 Deductibles and Copayments

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

4.18 Dental Services

This *agreement* does NOT cover:

- general dental services such as extractions (including full mouth extractions), prostheses, braces, operative restorations, fillings, medical or surgical treatment of dental caries, gingivitis, gingivectomy, impactions, periodontal surgery, non-surgical treatment of temporomandibular joint dysfunctions, including appliances or restorations necessary to increase vertical dimensions or to restore the occlusion;
- panorex X-rays or dental X-rays (except when ordered by a *doctor* or dentist to diagnose a condition due to an accident to your *sound natural teeth*. See Section 3.11 - Emergency Services for details);

- orthodontic services, even if related to a covered surgery;
- dental appliances or devices; and
- *hospital services*, *free-standing ambulatory surgi-center* services, and anesthesia services provided in connection with a dental service when the use of the *hospital* or *free-standing ambulatory surgi-center* or the setting in which the services are received is not *medically necessary*.

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

- apicoectomy, per tooth, first root;
- alveolectomy including curettage of osteitis or sequestrectomy;
- alveoloplasty, each quadrant;
- complete surgical removal of inaccessible impacted mandibular tooth mesial surface;
- excision of feberous tuberosities;
- excision of hyperplastic alveolar mucosa, each quadrant;
- operculectomy excision periocoronal tissues;
- removal of partially bony impacted tooth;
- removal of completely bony impacted tooth, with or without unusual surgical complications;
- surgical removal of partial bony impaction;
- surgical removal of impacted maxillary tooth;
- surgical removal of residual tooth roots; or
- vestibuloplasty with skin/mucosal graft and lowering the floor of the mouth.

4.19 Employment–Related Injuries

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

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

4.20 Eye Exercises

Eye exercises and visual training services are NOT covered.

4.21 Eyeglasses and Contact Lenses

Eyeglasses and contact lenses are NOT covered unless specifically listed as a *covered health care service* in this *agreement*.

4.22 Food and Food Products

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

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

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

4.24 Gene Therapy, Genetic Screening, and Parentage Testing

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

4.25 Illegal Drugs and Chronic Addiction

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

4.26 Infant Formula

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

4.27 Marital Counseling

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

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

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

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

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

- standers,
- raised toilet seats,
- toilet seat systems,
- cribs,
- ramps,
- positioning wedges,
- wall or ceiling mounted lift systems,
- water circulating cold pads (cryo-cuffs),
- car seats (including any vest system) or car beds,
- bath or shower chair systems,
- trampolines,
- tricycles,
- therapy balls, or
- net swings with a positioning seat.

4.29 Psychoanalysis for Educational Purposes

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

4.30 Research Studies

Research studies are only covered as described in Section 3.12 .

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

4.32 Services Provided By Relatives or Members of Your Household

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

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

4.34 Supervision of Maintenance Therapy

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

4.35 Surrogate Parenting

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

4.36 Therapies, Acupuncture and Acupuncturist Services, and Biofeedback

This *agreement* does NOT cover:

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

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

This *agreement* does NOT cover:

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

4.37 Weight Loss Programs

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

5.0 HOW YOUR COVERED HEALTH CARE SERVICES ARE PAID

Payments we make to you are personal and you cannot transfer or assign any of your right to receive payments under this *agreement* to another person or organization.

5.1 How Network Providers Are Paid

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

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

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

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

5.2 How Non-Network Providers Are Paid

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

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

Generally, our payment for *non-network provider* services will not be more than the amount we pay for *network provider* services. Payments we make to you are personal. You cannot transfer or assign any of your right to receive payments under this *agreement* to another person or organization.

5.3 Coverage for Services Provided Outside of the Service Area

Out-of-Area Services

[Insert NHPRI out-of-area coverage policy]

Non-Participating Healthcare Providers Outside Our Service Area

Subscriber Liability Calculation

When covered health care services are provided outside of our service area by *non-network* health care *providers*, the amount you pay for such services will generally be based on *[NHPRI to insert appropriate provision]*

Exceptions

In certain situations, we may use other payment bases, such as billed covered charges or the payment we would make if the health care services had been obtained within our service area, to determine the amount we will pay for services rendered by *non-network* health care *providers*. In these situations, you may be liable for the difference between the amount that the *non-network* health care *provider* bills and the payment we will make for the covered

ervices as set forth in this paragraph.

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

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

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

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

6.1 Definitions

The following definitions apply to Section 6:

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

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

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

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

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

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

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

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

6.2 When You Have More Than One Agreement with Neighboorhood Health Plan of Rhode Island

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

6.3 When You Are Covered By More Than One Insurer

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

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

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

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

(1 Non-Dependent/Dependent - If you are covered under a *plan* and you are the main *subscriber*, the *benefits* of that *plan* will be determined before the *benefits* of a *plan* which covers you as a dependent. If, however, you are a Medicare beneficiary, then, in some instances, Medicare will be Secondary and the *plan* which covers you as the main *subscriber* or as a dependent will provide the benefits first.

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

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

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

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

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

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

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

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

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

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

Total Benefits Payable

6.4 Our Right to Make Payments and Recover Overpayments

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

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

7.0 HOW TO FILE AND APPEAL A CLAIM

Our Customer Service Department phone number is (401) 459-000 or 1-800-963-1001.

7.1 How to File a Claim

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

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

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

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

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

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

Please mail the *claim* to:

Neighborhood Health Plan of Rhode Island
299 Promenade Street
Providence, RI 02908

7.2 Complaint and Administrative Appeal Procedures

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

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

- the services were excluded from coverage;
- we failed to make payment (in whole or part) for a service;
- we determined that you were not eligible for coverage (for example, a *rescission* of coverage occurred);
- you or you or your *provider* did not follow Neighborhood Health Plan of Rhode Island's requirements; or
- other limitation on an otherwise covered benefit.

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

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

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

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

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

Neighborhood Health Plan of Rhode Island
Attention: Grievance & Appeals
299 Promenade Street
Providence, RI 02908

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

Complaint

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

- **Level 2 (when applicable)**
  A Level 2 *complaint* may be submitted only when you have been offered a second level of *complaint* in your Level 1 determination letter. The Grievance and Appeals Unit will

conduct a thorough review of your Level 2 *complaint* and respond to you in writing within thirty (30) business days of the date we receive your Level 2 letter. Our determination letter will provide you with the rationale for our response as well as information on the next steps if you are not satisfied with the outcome of the *complaint*.

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

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

7.3 Medical Appeal Procedures

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

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

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

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

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

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

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

Written *medical appeals* should be sent to:

Rhode Neighborhood Health Plan of Rhode Island
Attention: Grievance & Appeals
299 Promenade Street
Providence, RI 02908

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

Within ten (10) business days of receipt of a written or verbal *medical appeal*, the Grievance and Appeals Unit will mail or call you to phone acknowledge of our receipt of the *medical appeal*.

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

Level 1 Review
You may request a Level 1 review of any matter subject to *medical appeal* by making a request for such review to us within one hundred and eighty (180) calendar days of the initial determination letter. You may ask for this review by calling our Customer Service Department, but we strongly suggest that you submit your request in writing to ensure your request is accurately reflected. At any time during the Level 1 Review (or Level 2 Review, see below), you may supply additional information by mailing it to the address listed above. You may request copies of information relevant to your appeal (free of charge) by contacting our Grievance and Appeal Unit.

For pre-service (before services are rendered) or concurrent (during a patient's hospital stay or course of treatment) appeals, you will receive written notification of the determination on a Level 1 review within fifteen (15) calendar days of receipt of the appeal request. If you are requesting reconsideration of a service that was denied after you already obtained the service (retrospectively), then you will receive written notification of our determination within fifteen (15) business days of our receipt of the appeal.

Level 2 Review
You may request a Level 2 review (preferably in writing) if our denial was upheld during the Level 1 review process. Your Level 2 review will be reviewed by a *provider* in the same or similar specialty as your treating *provider*. You must submit your request for a Level 2 review within one hundred and eighty (180) calendar days of receipt of the Level 1 determination letter. Upon request for a Level 2 review, we will provide you with the opportunity to inspect the medical file and add information to the file.

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

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

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

A review is considered emergent or urgent if, in the opinion of an individual applying the judgment of a prudent layperson possessing an average knowledge of health and medicine,

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

To request you or your physician or provider must call the Grievance and Appeals Unit at (401) 459-6000 or 1-800-963-1001 or fax your request to (401) 459-5005.

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

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

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

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

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

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

7.4 Legal Action

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

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

Under state law, you may not begin court proceedings prior to the expiration of sixty (60) days after the date you filed your claim. In no event may legal action be taken against us later than three (3) years from the date you were required to file the claim (see Section 6.1).

7.5 Grievances Unrelated to Claims

We encourage you to discuss any *complaint* that you may have about any aspect of your medical treatment with the health care *provider* that furnished the care. In most cases, issues can be more easily resolved when they are raised when they occur. If, however, you remain

dissatisfied or prefer not to take up the issue with your *provider*, you may access our *complaint* and grievance procedures.

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

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

7.6 Our Right to Withhold Payments

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

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

7.7 Our Right of Subrogation and/or Reimbursement

Definitions

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

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

Subrogation

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

Reimbursement

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

We can collect the money no matter where it is or how it is designated. You must pay us back even if you do not get back the total amount of your claim against the third party. We can collect the money you receive even if it is described as a payment for something other than health care expenses. We may offset future payments under this *agreement* until we have been paid an amount equal to what you were paid by a third party. If we must pay legal fees in order to recover money from you, we can recover these costs from you. Also, the amount that you must pay us cannot be reduced by any legal costs that you have.

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

Member Cooperation

You must give us information and help us. This means you must complete and sign all necessary documents to help us get money back. You must tell us in a timely manner about the progress of your claim with a third party. This includes filing a claim or lawsuit, beginning settlement discussions, or agreeing to a settlement in principle, etc. It also means that you

must give us timely notice before you settle any claim. You must not do anything that might limit our rights under this Section. We may take any action necessary to protect our right of *subrogation* and/or *reimbursement*.

8.0 GLOSSARY

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

AGREEMENT means this document. It is a legal contract between you and Neighborhood Health Plan of Rhode Island.

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

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

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

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

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

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

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

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

- by impaired functioning;
- debilitating physical condition;
- the inability to keep from or reduce consuming the substance; OR
- the need for daily use of the chemical in order to function.

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

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

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

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

CONTRACT YEAR means a twelve (12) month period.

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

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

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

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

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

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

EMERGENCY means a medical condition manifesting itself by acute symptoms. The acute symptoms are severe enough (including severe pain) that a prudent layperson, with an

average knowledge of health and medicine, could reasonably expect that without immediate medical attention serious jeopardy to the health of a person (or, with respect to a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions, or serious dysfunction of any bodily organ or part could result.

EXCHANGE means the Rhode Island Health Benefits Exchange as originally established by Executive Order Number 11-09 to enable people to easily compare health insurance options, learn if they qualify for tax credits, and sign up for health insurance.

EXPERIMENTAL/INVESTIGATIONAL means any health care service that has progressed to limited human application, but has not been recognized as proven and effective in clinical medicine. See Section 3.12 for a more detailed description of the type of health care services we consider *experimental/investigational*.

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

HOSPITAL means any facility worldwide:

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

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

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

Hospital does not mean:

- convalescent homes;
- rest homes;
- nursing homes;
- homes for the aged;
- school and college infirmaries;
- halfway houses or residential facilities;
- long-term care facilities;
- *urgent care centers* or *free-standing ambulatory surgi-centers;*
- facilities providing mainly custodial, educational or rehabilitative care; or
- sections of *hospitals* used for custodial, educational or rehabilitative care, even if accredited by the JCAHO or listed in the AHA directory.

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

- anesthesia supplies;
- blood services including: administration, typing, crossmatching, drawing, maintenance of

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

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

LEVEL OF COVERAGE means the amount that we pay for a *covered health care service*. A *copayment*, *deductible,* or *maximum benefit* may be applied. The *level of coverage* differs depending on whether you are treated by a *network* or a *non-network provider*. See the Summary of Benefits for details about your *level of coverage*.

MAINTENANCE SERVICES means any service that is intended to maintain current function, slow down, or prevent decline in function. *Maintenance services* are most often long term therapies that do not apply to persons with an acute chronic illness or functional deficit. See Section 4.35 - Supervision of Maintenance Therapy and Maintenance Services.

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

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

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

MAXIMUM OUT-OF-POCKET EXPENSE means the total amount of *copayments* that you must pay each *contract year* for certain *covered health care services.*

Unless otherwise indicated, we will pay up to 100% of our *allowance* for the rest of the *contract year* once you have met the *maximum out-of-pocket expense*.

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

MEDICALLY NECESSARY means that the health care services provided to treat your illness or injury, upon review by Neighborhood Health Plan of Rhode Island are:

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

We will make a determination whether a health care service is *medically necessary.* You have

the right to appeal our determination or to take legal action as described in Section 7.0.

We review medical necessity on a case-by-case basis.

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

NETWORK PROVIDER (NETWORK) is a *provider* that has entered into an agreement with us.

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

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

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

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

PLAN means any *hospital* or medical service *plan* or health insurance benefit package provided by an organization. This includes:

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

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

Preauthorization is the approval that we advise you to seek before receiving certain *covered health care services.* Selected prescription drugs bought at a pharmacy require *prescription drug preauthorization*. (See Section 3.29 for details.) *Preauthorization* ensures that services are *medically necessary* and performed in the most appropriate setting. *Network providers* are

responsible for obtaining *preauthorization* for all applicable *covered health care services*. You are responsible for obtaining *preauthorization* when the *provider* is *non-network*. If you do not obtain *preauthorization* and the services are determined to be not *medically necessary* or the setting in which the services were received is determined to be inappropriate, we will not cover these services/facilities.

You may ask for *preauthorization* by telephoning us. For *covered health care services* (other than behavioral health services), call our Customer Service Department at (401) 459-6000 or 1-800-963-1001.

For behavioral health services (mental health and *chemical dependency*) call 1-800-215-0058.

We encourage you to contact us at least two (2) working days before you receive any *covered health care service* for which *preauthorization* is recommended.

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

PREVENTIVE CARE SERVICES means *covered health care services* performed to prevent the occurrence of disease. See Section 3.30 - *Preventive Care Services* and Early Detection Services.

PRIMARY CARE PROVIDER ("PCP") means a *network provider* who provides primary care services (including family practice, general practice, internal medicine, obstetrics and gynecology, and/or pediatrics), manages routine health care needs and has been identified as the *Primary Care Provider* for one or more *members.*

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

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

These individuals include:

- midwives;
- certified registered nurse practitioners;

- psychiatric and mental health nurse clinical specialists practicing in collaboration with or
- in the employ of a physician licensed in Rhode Island;
- counselors in mental health; and
- therapists in marriage and family practice.

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

The services must be

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

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

See Section 3.36 - Speech Therapy and the Summary of Medical Benefits for *benefit limits* and *level of coverage*.

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

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

SUBSCRIBER/MEMBER means you and each *eligible person* listed on your application whom we agree to cover.

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

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

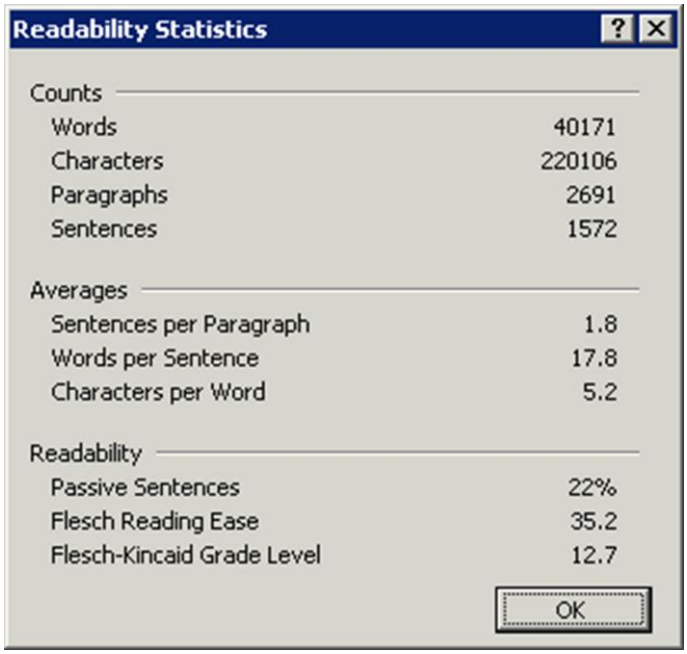
health care service under this *agreement.*

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

WE, US, and **OUR** means Neighborhood Health Plan of Rhode Island. We are located at 299 Promenade Street, Providence, Rhode Island, 02908. In this *agreement,* WE, US, or OUR will have the same meaning whether italicized or not.

YOU and **YOUR** means the person who is subscribing to Neighborhood Health Plan of Rhode Island. In this *agreement,* YOU and YOUR will have the same meaning whether italicized or not.

Readability Test



299 Promenade Street
Providence, RI 02908

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

☑ **INDIVIDUAL HEALTH BENEFIT PLANS** ***(Complete SECTION A only)***

☐ **SMALL / LARGE GROUP HEALTH BENEFIT PLANS** ***(Complete SECTION B only)***

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as "major medical" in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. (*If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.*)

***For all filings, include the Type of Insurance (TOI) in the first column.**

☐ Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
Neighborhood Health Plan of Rhode Island	95402	NHRI-128913451	Ind Mkt 1, 2 & 3	☑ Yes ☐ No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
H16I	**Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19**	*[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

Reset Form

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 of the PHSA/Section 1201 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes**◊ ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

◊ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

Checklist for Individual and Small Group Health Insurance Plans - Policy Form
Inside and Outside the Rhode Island Health Benefit Exchange
Effective for plan years beginning on and after 1-1-2014

Company Name Neighborhood Health Plan of Rhode Island

Product Name: Neighborhood Health Plan Exchange Product 2014 – Individual Market

Plan Name: XXXX

Issuer is:
☐ certified by the Health Benefits Exchange as a QHP issuer
X licensed by OHIC to do health insurance business in RI

SERFF tracking number: NHRI-128972321
TOI Code and Sub Code: H16I – Individual Health – Major Medical
H16G.005C Individual Other

☐60% AV (Bronze)
X 70% AV (Silver)

X 80% (Gold)
☐ 90% (Platinum)
☐ Child-only
☐ Catastrophic Plan - 42 U.S.C. § 18022(e)

Filed for issuance: Inside the Exchange X Outside the Exchange ☐ Inside and Outside the Exchange ☐
Individual Market X Small Group Market☐SHOP ☐ ☐

Instructions for Checklist:

A. The Checklist for Individual and Small Group Health Insurance Plans ("Checklist") must be completed for all major medical health insurance plan policy forms offered by a health insurance issuer ("Issuer") in the individual market and in the small group market, including individual Qualified Health Plans ("QHP's") and SHOP QHP's offered on the Rhode Island Health Benefit Exchange ("Exchange").
B. The Checklist does not apply to large group health insurance plans, dental plans, or Medicare Supplemental insurance plans.
C. The terms of applicable laws and regulations shall supersede this Checklist in the case of a conflict. The omission of any requirement of the law or of a regulation from this Checklist in no way limits the authority of the Office of the Health Insurance Commissioner to enforce any other such requirement.
D. A filer shall not change or revise the Checklist.
E. By checking the "Yes" box, the Issuer certifies that the referenced provision of the health insurance plan ("Plan") complies with the associated requirement, and that the referenced provision does not contain any inconsistent, ambiguous, unfair, inequitable, or misleading clauses, or exceptions of conditions that unreasonably affect the risk purported to be assumed.

Checklist for Individual and Small Group Health Insurance Plans - Policy Form
Inside and Outside the Rhode Island Health Benefit Exchange
Effective for plan years beginning on and after 1-1-2014

F. By checking the box "N/A", the Issuer certifies that Plan does not have to comply with the associated requirement. An Explanation must be provided if this box is checked.

G. This Checklist is established by the Commissioner of the Office of the Health Insurance Commissioner ("OHIC") pursuant to OHIC Regulation 17 - "Filing and Review of Health Insurance Plan Forms and Rates." The Checklist is intended to communicate the Commissioner's considered opinion concerning what a Plan form must contain in order to satisfy the statutory and regulatory standards for approval of the form. See R.I. Gen. Laws §§ 27-18-8, 27-19-6, 27-20-6, and 27-41-29.2.

H. The Commissioner may revise the Checklist from time to time. The Checklist, and any revisions to the Checklist, will be posted on SERFF as Filing Instructions for Rhode Island.

I. The filing shall include an actuarial memorandum demonstrating the calculation and analysis used to determine: (a) the Plan's actuarial value rating, and if applicable, (b) the Plan's Catastrophic Plan status, (c) the actuarial equivalence of Essential Health Benefit substitutions, and (d) the conversion of annual or lifetime dollar limits for Essential Health Benefits to a permitted limitation.

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
General Requirements				
1. The filing must contain the entire health insurance plan policy form. • If the filer requests approval of any section, paragraph or other text in the Plan based on prior approval of the text by OHIC, the filer must identify the previously approved filing, and the page, section and paragraph where the text appears in the previously approved filing.	RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2. OHIC Regulation 17		X ☐	☐ X
Explanation: We will not provide an redline version based on OHICs request; CoC is being revised; June 1st completion date formally requested on April 11; periodic updates and reviews will be provided to OHIC				
· 2. If changes to a previously approved form are filed, the filing shall include a red-lined version of the previously approved form, and a clean version of the form as proposed to be amended.	RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2. OHIC Regulation 17		☐	X
Explanation: We will not provide an redline version based on OHICs request; CoC is being revised; June 1st completion date formally requested on April 11; periodic updates and reviews will be provided to OHIC				
3. All forms must be filed in a word-searchable format.	RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2 OHIC Regulation 17		X	☐

Checklist for Individual and Small Group Health Insurance Plans - Policy Form
Inside and Outside the Rhode Island Health Benefit Exchange
Effective for plan years beginning on and after 1-1-2014

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
Explanation:				
4. Readability. • Forms must comply with the requirements of OHIC Regulation 5, "Standards for the Readability of Health Insurance Forms". • The filing must include a Readability Certification in accordance with OHIC Regulation 5.	45 CFR §156.265(e) RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2 OHIC Regulation 5	See Page 119	X X	☐ ☐
Explanation:				
5. The filing must include the "Compliance Attestation - Forms", attached hereto as Exhibit A.	RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2. OHIC Regulation 17.	Attestation Forms Filed Separately in SERFF	X	☐
Explanation:				
Standard Policy Provisions 6. The Plan complies with state laws and regulations relating to: • The Form of the Plan. • Required Provisions • Individual Health Benefit Contracts • Group and Blanket Health Benefit Contracts	 R.I. Gen. Laws § 27-18-2 R.I. Gen. Laws § 27-18-3 OHIC/DBR Regulation 23, Part VII OHIC/DBR Regulation 23, Part VIII		 X X X X	 ☐ ☐ ☐ ☐
Explanation:				

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Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
Form Content Requirements				
7. Essential Health Benefits ("EHB") a) The Plan must cover each of the 10 categories of Essential Health Benefits: o Ambulatory patient services o Emergency services o Hospitalization o Maternity and newborn care o Mental health and substance use disorder services, including behavioral health treatment o Prescription drugs o Rehabilitative and habilitative services and devices o Laboratory services o Preventive and wellness services and chronic disease o Pediatric services, including oral and vision care	42 U.S.C. § 18022 45 C.F.R. § 156.100 et seq.		X	☐
b) The provisions of this Section 7 apply to benefits and services covered under the Plan. The provisions of this Section 7 do not apply to cost sharing, and do not apply to utilization review standards and procedures.				
c) The Plan must cover each and every service covered in the EHB-Benchmark Plan. The components of the EHB-Benchmark Plan are: (1) the Blue Cross Vantage Blue Small Group plan ("the Base-Benchmark Plan"), including the prescription drug benefits covered by the Base-Benchmark Plan; (2) the pediatric dental benefits covered under the MetLife Federal Dental plan; (3) the pediatric vision benefits covered under the FEP Blue Vision plan; and (4) habilitative services as determined and required by subsection (h), below. **Note:** OHIC considers each of the benefits and services covered in the Base-Benchmark Plan to be included within one of the 10 Essential Health Benefits listed in subsection			X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
(a), above. If the filer proposes to exclude a benefit or service covered in the R.I. Benchmark Selections, because the filer considers the benefit or service to be not included within one of the 10 Essential Health Benefits listed in subsection (a), above, the filer must identify such benefit or services, and provide a written explanation for the exclusion. The components of the EHB-Benchmark Plan (other than habilitation services required by subsection (h), below, can be found at the following address on the OHIC website: http://www.ohic.ri.gov/2010%20Health_Reform.php				
d) The Plan must cover the services covered in the EHB-Benchmark Plan, including but not limited to each and every state benefit mandate covered in the Base-Benchmark Plan.			X	☐
e) Prescription drugs. ○ The filer must include the Plan's prescription drug formulary with the filing.			X	☐
○ The Plan must cover the greater of: (i) one drug in each United States Pharmacopeia ("USP") category or class, or (ii) the same number of prescription drugs covered in the Base-Benchmark Plan.			X	☐
○ The Plan may substitute a prescription drug covered under the Base-Benchmark Plan, provided that the substituted drug covered under the Plan is in the same USP category or class as the drug covered under the Base-Benchmark Plan. The Issuer shall identify any drug substitutions, and shall verify that the therapeutic category or class of the substituted drug covered under the Plan is the same as the therapeutic category or class of the drug covered under the Base-Benchmark Plan. In the case of formulary substitutions during the Plan year, the Issuer shall file on SERFF a notification (not subject to prior approval) identifying the substitution that has			X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
been made, and verifying that the USB category or class of the substituted drug covered under the Plan is the same as the USP category or class of the drug covered under the Base-Benchmark Plan. o The Plan shall describe the process for an enrollee to request and receive coverage of clinically appropriate drugs not on the Plan's formulary.		See Section 3.29, Pg 40	X	☐
f) A Plan that is offered outside the Exchange must cover the pediatric dental services covered by the EHB-Benchmark Plan (the MetLife Federal Dental plan for federal employees), for enrollees 18 years of age or younger; except that a Plan that is offered outside the Exchange is not required to cover the pediatric dental services covered by the EHB-Benchmark Plan if the Issuer determines, after reasonable inquiry, that the individual or small group policyholder is covered under a dental insurance plan that covers the pediatric dental services covered by the EHB-Benchmark Plan. If the individual or small group policyholder is already covered under a dental insurance plan that covers the pediatric dental services covered by the EHB-Benchmark Plan, the Issuer shall not offer the Plan with pediatric dental services; instead, the Issuer must offer a Plan that excludes pediatric dental coverage, with a premium discount equivalent to the per member per month cost of pediatric dental coverage. The Issuer's rate filing for the Plan shall include the proposed premium for the Plan with and without pediatric dental services.			☐ X	X ☐
g) The Plan must cover the pediatric vision services covered under EHB-Benchmark Plan (the FEP Blue Vision plan for federal employees) for enrollees 18 years of age or younger.		See Section 3.39, Page 82	X	☐
h) The Plan must cover habilitative services as approved by the Commissioner, in accordance with the following: Habilitative services covered under the Plan must be defined by scope, and		See Section 3.39, Page 84	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
must be at least as comprehensive (measured by per member per month cost) as the per member per month cost of rehabilitation services covered under the plan. Service visit limitations or other durational or quantitative limitations will be approved by the Commissioner only if the filer can demonstrate that no other qualitative, evidenced-based limitations less burdensome to the consumer (e.g. a process for developing limitations based on individual assessments of need) are feasible and appropriate. The filer must attach in the filing an Exhibit that (1) identifies the habilitative services covered by the plan, (2) includes an actuarial memorandum estimating the per member per month cost of the habilitative and rehabilitative services covered, and (3) includes in the actuarial memorandum the calculation and analysis used to develop the identified cost. No later than 90 days after the end of each calendar year, the Issuer must file with OHIC an actuarial memorandum, using the best available claims data, describing the Plan's claims and expense experience for habilitative and rehabilitative services during the preceding Plan year, and comparing such claims and expense experience with the approved rate factor.			X	☐
i) Substitutions. o A Plan may substitute a benefit or service for a benefit or service covered under the EHB-Benchmark Plan only if: (1) the Plan's substitute benefit or service is included within the same Essential Health Benefit category (see subsection (a), above) as the benefit or service covered under the EHB-Benchmark Plan; (2) the substitute benefit or service and the substituted benefit or service are actuarially equivalent; and (3) the substitution is approved by the Commissioner. o The filer must identify the substitution, and must file an actuarial memorandum demonstrating that the substitution is actuarially equivalent.			X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
j) A Plan may include a material deviation from a benefit or service for a benefit or service covered under the EHB-Benchmark Plan only if (1) the deviation is identified; (2) the Issuer files a memorandum demonstrating that the deviation is substantially equivalent to the EHB-Benchmark Plan; and (3) the deviation is approved by the Commissioner.			X	☐
Explanation: **NHPRI will not operate plans outside of the Exchange; therefore Pediatric Dental is not included**				
8. Cost-sharing. • Out of pocket limits. The Issuer must demonstrate in an Exhibit filed with the Plan that annual out of pocket cost sharing under the Plan does not exceed the limits established by federal and state laws and regulations, including any revisions to this Checklist. • Deductible limits. For small group Plans, the Issuer must demonstrate in an Exhibit filed with the Plan that annual deductibles under the Plan do not exceed the limits established by federal and state laws and regulations, including any revisions to this Checklist.	42 U.S.C. § 18022(c) 45 C.F.R. § 156.130(a)		X X	☐ ☐
Explanation:				
9. The Plan must contain no preexisting condition exclusions.	42 U.S.C. § 300gg-3 RI Gen Law §§ 27-18-71, 27-18.5-10, 27-19-68, 27-20-57, 27-41-81	See Page 37	X	☐
Explanation:				

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Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
10. Lifetime dollar limits. • The Plan must contain no lifetime limits on the dollar value of any Essential Health Benefits, including the specific benefits and services covered under the EHB-Benchmark Plan. See Para. 7, above. • If the specific benefits and services covered under the Base-Benchmark Plan (See Para. 7, above) include dollar limits on the coverage of any such benefit or service, the Plan may propose an actuarially equivalent conversion of the dollar limit to a utilization limit, or some other quantitative or qualitative limit, subject to the Commissioner's approval. • If the Plan proposes a conversion the Issuer must file with the Plan an actuarial memorandum supporting the actuarially equivalent conversion.	PHSA §2711 45 CFR §147.126 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2		X ☐	☐ X X
Explanation: **Plan does not include any lifetime dollar or utilization limits for EHB**.				
11. Annual dollar limits. a) The Plan must contain no lifetime limits on the dollar value of any Essential Health Benefits, including the specific benefits and services covered under the EHB-Benchmark Plan. See Para. 7, above. b) If the specific benefits and services covered under the Base-Benchmark Plan (See Para. 7, above) include dollar limits on the coverage of any such benefit or service, the Plan may propose an actuarially equivalent conversion of the dollar limit to a utilization limit, or some other quantitative or qualitative limit, subject to the Commissioner's approval. **c)** If the Plan proposes a conversion the Issuer must file with the Plan an actuarial memorandum supporting the actuarially equivalent conversion.	42 U.S.C. § 300gg-11 45 CFR §147.126 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2		X X ☐	☐ ☐ X
Explanation: **Plan does not include any annual dollar or utilization limits for EHB**				

Requirement	Federal & State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
12. The Plan must state that the Issuer may not rescind the Plan except in cases of fraud or intentional misrepresentation of material fact. The Plan must also state that coverage may not be contested 2 years after issuance of the Plan for any reason. • Rescission is a cancellation of coverage that has retroactive effect. It includes a cancellation that voids benefits paid. • Coverage may not be rescinded except with 30 days prior notice to each enrolled person who would be affected.	42 U.S.C. § 300gg-12 45 CFR §147.128 RI Gen Law §§ 27-18-8, 27-18-72, 27-19-6, 27-19-62, 27-20-6, 27-20-58, 27-41-29.2 OHIC/DBR Reg. 23 Part VIII, Section 1(2)	See Section 2.4; Page 34 Being Revised	X	☐
Explanation:				
13. The Plan must cover preventive services without cost sharing requirements including deductibles, co-payments, and co-insurance. • Covered preventive services include: o Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the USPSTF; o Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (CDC); o Evidence-informed preventive care and screenings provided for in HRSA guidelines for infants, children, adolescents, and women; and o Current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention.	PHSA §2713 45 CFR §147.130 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2	See Section 3.3, Page 72	X	☐
Explanation:				
14. The Plan must provide coverage for dependents up to age 26 if the Plan offers dependent coverage. • Eligible children are defined based on their relationship with the participant.	42 U.S.A. § 300gg-14 45 CFR §147.120	See Page 4	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
• Limiting eligibility is prohibited based on: o financial dependency on primary subscriber, o residency, o student status, o employment, o eligibility for other coverage, o marital status. • Terms of the policy for dependent coverage cannot vary based on the age of a child.	RI Gen Law §§ 27-18-59, 27-19-50, 27-20-45, 27-41-61			
Explanation:				
15. The Plan must cover emergency services in accordance with the following: • No prior authorization. • No limitation to only services and care at participating providers. • Must cover at in-network cost-sharing level (patient is not penalized for emergency care at out-of-network provider). • Must pay for out-of-network emergency services the greatest of: (1) The median in-network rate; (2) the usual customary and reasonable rate (or similar rate determined using the plans or issuer's general formula for determining payments for out-of-network services); or (3) the Medicare rate.	42 U.S.C. § 300gg-19a(b) 45 CFR §147.138 RI Gen Law §§ 27-18-76, 27-19-66, 27-20-62, 27-41-79 SSA §1395dd	See Section 3.11; Page 48	X	☐
Explanation:				
16. For network plans requiring a primary care provider to be designated and requiring referrals: • The Plan must allow each enrollee to designate any participating primary care provider who is available to accept such individual. • The Plan must permit a physician specializing in pediatrics to	42 U.S.C. § 300gg-19a(a), (c), and (d) 45 CFR §147.138	See Section 1.12; Page 1.11 And Glossary (PCP Def)	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
be designated as primary care provider. • The Plan must not require a referral for services to be provided by in-network OB/GYNs. The Plan must treat the ordering of OB/GYN items or services by an OB/GYN as it had been ordered or authorized by the primary care provider.	RI Gen Law §§ 27-18-44		X X	☐ ☐
Explanation:				
17. In connection with maternity coverage, the Plan must provide coverage as follows: • Benefits may not be restricted to less than 48 hours following a vaginal delivery, and 96 hours following a cesarean section. This requirement does not apply if the provider, in consultation with the mother, decides to discharge the mother or the newborn prior to the minimum length of stay. • No prior authorization required for the minimum hospital stay. • For purposes of maternity coverage requirements, hospital length of stay begins at the time of delivery if delivery occurs in a hospital and at time of admission in connection with childbirth if delivery occurs outside the hospital. • No denial of mother/newborn eligibility, continued eligibility, to enroll or to renew coverage to avoid these requirements. • No monetary payments or rebates to encourage mothers to accept less than the minimum stay requirements. • No penalty for an attending provider who provides services in accordance with these requirements. • No incentives to an attending provider to induce the provider to provide care inconsistent with these requirements. • No restriction of benefits for any portion of a period within the minimum stay periods in a manner less favorable than the benefits provided for any preceding portion of such stay. • No requirement that the mother give birth in a hospital.	42 U.S.C. § 300gg-25 45 CFR §148.170 RI Gen Law §§ 27-18-33.1, 27-19-23.1, 27-20-17.1, 27-41-33.1, 27-41-43 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2	See Section 3.28; Page 38	X X	☐ ☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
• No requirement that the mother to stay in the hospital for a fixed period of time following the birth of her child.				
Explanation:				
18. The Plan must state that it provides, and must provide coverage for parity in mental health and substance use disorder benefits ("Parity"), 40in accordance with the following: • Coverage for the medical treatment of mental illness and substance abuse must be provided under the same terms and conditions as that coverage is provided for other illnesses and diseases. • The Plan must describe, through illustrations, FAQ's, or other consumer explanation how the Plan provides for Parity in connection with financial requirements, quantitative treatment limitations, prescription drug benefits, and non-quantitative treatment limitations.	42 U.S.C. § 300gg-26 45 CFR §146.136 RI Gen Law § 27-38.2-1	See Section 3.2; Page 40	X	☐
Explanation:				
19. The Plan must provide coverage for reconstructive surgery after mastectomy (Women's Health and Cancer Rights Act). The Plan must describe, through illustrations, FAQ's, or other consumer explanation how the Plan covers reconstructive surgery after mastectomy, including the scope of coverage, and cost-sharing consistent with other medical/surgical benefits.	PHSA §2727 RI Gen Law §§27-8-39, , 27-20-29, 27-41-43 OHIC Reg. 17	See Section 3.7; Page 80	X	☐
Explanation:				
20. The Plan must state that coverage is guaranteed renewable, and that the Issuer may non-renew or cancel coverage under the Plan only for nonpayment of premiums, fraud, market exit, movement outside of service area, or cessation of bona-fide association membership.	PHSA §2702 45 CFR §148.122	See Section 2.5; Page 35	X	☐

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	RI Gen Law § 27-18.5-4			
Explanation:				
21. The Plan must state that it does not limit coverage based on genetic information. 22. The Plan must state that the Issuer will not: (i) adjust premiums based on genetic information; (ii) request /require genetic testing; (iii) or collect genetic information from an individual prior to, or in connection with enrollment in a plan, or at any time for underwriting purposes.	PHSA §2753 45 CFR §148.180 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2	See Section 3.0; Page 38	X X	☐ ☐
Explanation:				
23. The Plan must provide coverage for individuals participating in approved clinical trials. The Plan must describe, through illustrations, FAQ's, or other consumer explanation how the Plan provides such coverage, including the scope of coverage, individuals qualified, clinical trials that will be approved, and network provider limitations.	42 U.S.C. § 300gg-8 RI Gen Law §§ 27-18-74, 27-19-64, 27-20-60, 27-41-77	See Section 3.12; Page 50	X	☐
Explanation:				
24. The Plan must state that the enrollee may terminate coverage upon no greater than 14 days notice to the Issuer or the Exchange. 25. For QHPs only, the Plan must state that the Issuer is permitted to terminate coverage if: • The enrollee is no longer eligible for coverage through the Exchange. • Payment of premiums cease (after appropriate grace periods	45 CFR § 155.430 45 CFR § 156.270(d) - (g) RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2 RI Gen Law § 27-18-3(a)(3);	See Section 2.4; Page 34 See Section 2.4; Pg 34; Being Revised	X X	☐ ☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
applied as described below); • The enrollee's coverage is rescinded for a non-prohibited reason. • The Qualified Health Plan is terminated or decertified. • The enrollee changes from one plan to another through during an open or special enrollment period.				
26. The Plan must state that if coverage is terminated, 30 days prior notice is required, and the notice must include the reason for termination.		See Section 2.4; Page 34 Being Revised	X	☐
27. The Plan must state that a 3 month grace period is provided for enrollees in a Qualified Health Plan who are recipients of advance payments of premium tax credit. The Issuer must provide the enrollee with notice of payment delinquency, unless the Exchange has accepted the obligation to do so on behalf of the Issuer.		See Section 2.4; Page 34; Being Revised	X	☐
28. For all other enrollees, the Plan must state that a 30 day grace period is provided.		See Section 2.4; Page 34; Being Revised	X	☐
Explanation:				
Claims, Internal Appeals, and External Appeals 29. The Plan must include a description of its claims procedures, procedures for obtaining prior approval, preauthorization procedures, utilization review procedures, adverse benefit determination procedures, internal appeals, external appeals, and **the** applicable time frames for these policies and procedures. Such policies and procedures must be in accordance with federal laws and regulations, in accordance with state laws and regulations that are not in conflict with such federal laws and regulations, and in accordance with the requirements of this checklist.	42 U.S.C. § 300gg-19 45 CFR § 147.136 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2 RI Gen Law §§ 23-17.12-1 et seq., 23-17-13-1 et seq. (where not in conflict with federal laws and regulations).	See Section 7; Page 101	X	☐
30. The Plan must include the standards, including the Plan's medical		See Section 7.3; Page 103	X	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
necessity standard, applicable to prior approval, preauthorization, and utilization review procedures. The Plan's definition of "medical necessity" must: • Require coverage of health care services that are appropriate, in terms of type, amount, frequency, level, setting, and duration to the member's diagnosis or condition. • Must be informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters.	DOH Regulations 23-17-12-UR and 23-17.13-CHP (where not in conflict with federal laws and regulations).			
31. The Plan must explain to the enrollee how to obtain the clinical review criteria used to determine medical necessity in a particular situation.		See Section 1.5; Page 27	X	☐
32. The Plan's definition of adverse benefit determination must be the definition used in 29 C.F.R. § 2560.530-1. The term also includes a rescission of coverage.		See Section 1.5; Page 27	X	☐
33. In connection with external appeals, the Plan must provide that: • The cost of an external appeal must be borne by the issuer. • The claimant must not be charged a filing fee greater than $25. • Restrictions on the minimum dollar amount of a claim are not allowed. • The decision of the Independent Review Organization is binding on the issuer.		See Section 7.3; Page 103	X	☐
Explanation:				