Subscriber Agreement

VantageBlue w/Rx $3/12/35/60/100

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

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

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

Peter Andruszkiewicz
President and Chief Executive Officer
HELPFUL TIPS

- Read all information provided, especially this Subscriber Agreement. Become familiar with services excluded from coverage (See Section 4.0 – Health Services Not Covered Under This Agreement.)
- In Section 8.0 – 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. BCBSRI should be notified immediately if your ID card is lost or stolen.
- Our list of network providers changes from time to time. You may want to call our Customer Service Department in advance to make sure that a provider is a network provider.
- You are encouraged to choose a personal physician. Although no referral from a personal physician is needed to receive covered health care services from a specialist physician, personal physicians can help manage health care services.
- You are encouraged to become involved in your health care treatment by asking providers about all treatment plans available and their costs. You also are encouraged to take advantage of the preventive health services offered under this agreement to help you stay healthy and find problems before they become serious.

IMPORTANT TELEPHONE NUMBERS AND WEBSITES

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

HealthSource RI – 1-855-683-6759

EyeMed Vision Care – 1-866-723-0513

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 Substance Abuse - call 1-800-274-2958 before having care. Lines are open 24 hours a day, 7 days per week. Please see Section 1.6 for details.

Required Preauthorization

Prescription drugs for which preauthorization is required are marked with the symbol (+) in the Summary of Pharmacy Benefits. Please see Section 1.6 and Section 3.27 for more information.
  - Prescription drugs - ask your prescribing physician to call the number listed for the “Pharmacist” on the back of your ID card. To see if prescription drug requires preauthorization, call our Customer Service Department or visit our Web site.
BlueCard Access- 1-800-810-BLUE (2583) or visit the BlueCard PPO Doctor and Hospital finder web page at www.bcbs.com.
SUMMARY OF MEDICAL BENEFITS

This is a summary of your medical benefit 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 medical 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, you will be responsible for the provider’s charge. You will then be reimbursed based on the lesser of the provider’s charge, our allowance, or the maximum benefit; less any copayments and deductibles, if any. The deductible and maximum out-of-pocket expense are calculated based on the lower of our allowance or the provider’s charge, unless otherwise specifically stated in this agreement.

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

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Description</th>
<th>Benefit Limit/Notes</th>
<th>Network Provider</th>
<th>Non-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>Individual Plan</td>
<td>Per plan year</td>
<td>$1,500</td>
<td>$3,000</td>
</tr>
<tr>
<td></td>
<td>Family Plan</td>
<td>Per plan year</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The plan 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 $1,500 towards the plan year family deductible.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maximum Out-of-Pocket Expense</strong></td>
<td>Individual Plan</td>
<td>Per plan year</td>
<td>$4,500</td>
<td>$6,750</td>
</tr>
<tr>
<td></td>
<td>Family Plan</td>
<td>Per plan year</td>
<td>$9,000</td>
<td>$13,500</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The plan 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 $4,500 towards the plan year family maximum out-of-pocket expense.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The **deductible** applies to both network and non-network services separately.

Services that apply the **deductible** and services that do NOT apply the **deductible** are indicated in the Summary of Medical Benefits and the Summary of Pharmacy Benefits.

The **maximum out-of-pocket expense** accumulates separately for network and non-network services.

The **deductible** and copayments (including, but not limited to, office visits copayments and prescription drug copayments) apply to the **maximum out-of-pocket expense**.
## Medical Benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>Service Type, Provider, or Place of Service</th>
<th>Benefit Limit</th>
<th>Network provider For a covered health care service you pay:</th>
<th>Non-network provider For a covered health care service you pay the difference between the charge amount and the allowance plus:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Your copayment</td>
<td>Your copayment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Does the deductible apply?</td>
<td>Does the deductible apply?</td>
</tr>
<tr>
<td>Ambulance</td>
<td>Ground</td>
<td>$50</td>
<td>NO</td>
<td>The level of coverage is the same as network provider.</td>
</tr>
<tr>
<td></td>
<td>Air/Water</td>
<td>Up to the maximum benefit of $3,000 per occurrence.</td>
<td>$50</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The level of coverage is the same as network provider.</td>
</tr>
<tr>
<td>Behavioral Health - Mental Health</td>
<td>Inpatient *</td>
<td>Unlimited days at a general hospital or a specialty hospital.</td>
<td>0%</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>Intermediate Care Services*</td>
<td>See Behavioral Health Section for details about partial hospital program, intensive outpatient program, adult intensive services, and child and family intensive treatment.</td>
<td>0%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>In the office/in your home rendered by PCP</td>
<td>PCP practices with PCMH model of care.</td>
<td>$15</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PCP does NOT practice with PCMH model of care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>For a member under nineteen (19)</td>
<td>$15</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For a member nineteen (19) and older $25</td>
<td></td>
<td>YES</td>
</tr>
<tr>
<td>Service</td>
<td>Service Type, Provider, or Place of Service</td>
<td>Benefit Limit</td>
<td>Network provider</td>
<td>Non-network provider</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For a covered health care service you pay:</td>
<td>For a covered health care service you pay the difference between the charge amount and the <em>allowance</em> plus:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Your copayment</td>
<td>Does the deductible apply?</td>
</tr>
<tr>
<td>In the office/in your home rendered by Specialist</td>
<td>$40</td>
<td>NO</td>
<td>40%</td>
<td>YES</td>
</tr>
<tr>
<td>Behavioral Health – Substance Abuse Treatment</td>
<td>Detoxification – unlimited days per plan year. Residential/Rehabilitation – unlimited days per plan year.</td>
<td>0%</td>
<td>YES</td>
<td>40%</td>
</tr>
<tr>
<td>In a Substance Abuse Treatment facility (outpatient), Intermediate Care Services *</td>
<td>Prescription drug coverage benefit level is based on type of service and site of service. See Summary of Pharmacy Benefits for details. See Behavioral Health Section for details about partial hospital program, intensive outpatient program, adult intensive services, and child and family intensive treatment.</td>
<td>0%</td>
<td>YES</td>
<td>40%</td>
</tr>
<tr>
<td>In the office/in your home rendered by PCP</td>
<td>PCP practices with PCMH model of care.</td>
<td>$15</td>
<td>NO</td>
<td>40%</td>
</tr>
<tr>
<td>Service</td>
<td>Benefit Limit</td>
<td>Network provider</td>
<td>Non-network provider</td>
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</tr>
<tr>
<td></td>
<td>For a covered health care service you pay:</td>
<td>For a member under nineteen (19)</td>
<td>For a covered health care service you pay the difference between the charge amount and the allowance plus:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Your copayment</td>
<td>Does the deductible apply?</td>
<td>Your copayment</td>
<td>Does the deductible apply?</td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>$15</td>
<td><strong>NO</strong></td>
<td><strong>NO</strong></td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>Chiropractic Medicine</td>
<td>For a member nineteen (19) and older $25</td>
<td><strong>NO</strong></td>
<td><strong>NO</strong></td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>In the office/in your home rendered by Specialist</td>
<td>$40</td>
<td><strong>NO</strong></td>
<td>$40</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>Dental Care</td>
<td>Benefit is limited to 18 weeks or 36 visits (whichever occurs first) per covered episode.</td>
<td><strong>0%</strong></td>
<td>$40</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>When services are due to accidental injury to sound natural teeth.</td>
<td><strong>0%</strong></td>
<td>$250</td>
<td><strong>0%</strong></td>
</tr>
<tr>
<td>Services connected to dental care performed in Outpatient Facility</td>
<td>See Section for benefit limitations.</td>
<td><strong>0%</strong></td>
<td>$40</td>
<td><strong>0%</strong></td>
</tr>
<tr>
<td>In an office (doctor or dentist)</td>
<td>When services are due to accidental injury to sound natural teeth.</td>
<td><strong>0%</strong></td>
<td>$40</td>
<td><strong>0%</strong></td>
</tr>
<tr>
<td>Service</td>
<td>Benefit Limit</td>
<td>Network provider</td>
<td>Non-network provider</td>
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<tr>
<td></td>
<td></td>
<td>Your copayment</td>
<td>Does the deductible apply?</td>
<td>Your copayment</td>
</tr>
<tr>
<td>Diabetic Services</td>
<td></td>
<td>0%</td>
<td>YES</td>
<td>40%</td>
</tr>
<tr>
<td>Diabetic equipment/ supplies provided by a licensed medical supply provider (other than a pharmacy.)</td>
<td>See the Summary of Pharmacy Benefits for benefit limits and level of coverage.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic equipment/ supplies purchased at a retail pharmacy.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visits</td>
<td></td>
<td>0%</td>
<td>NO</td>
<td>40%</td>
</tr>
<tr>
<td>Podiatrist Services</td>
<td>First routine visit of a plan year. See Section 3.0 for details.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision Care Service</td>
<td>First routine eye exam of a plan year that includes a retinal eye exam.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis Services</td>
<td></td>
<td>0%</td>
<td>YES</td>
<td>40%</td>
</tr>
<tr>
<td>Inpatient/ Outpatient/in your home</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Service Type, Provider, or Place of Service</td>
<td>Benefit Limit</td>
<td>Network provider</td>
<td>Non-network provider</td>
</tr>
<tr>
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</tr>
<tr>
<td>Durable Medical Equipment, Medical Supplies, Enteral Formula and Food, and Prosthetic Devices</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Durable Medical Equipment*</td>
<td>Preauthorization recommended for certain services. Must be provided by a licensed medical supply provider.</td>
<td>20%</td>
<td>YES</td>
<td>40%</td>
</tr>
<tr>
<td>Outpatient Medical Supplies*</td>
<td>Must be provided by a licensed medical supply provider.</td>
<td>20%</td>
<td>YES</td>
<td>40%</td>
</tr>
<tr>
<td>Outpatient Prosthesis*</td>
<td>Must be provided by a licensed medical supply provider.</td>
<td>20%</td>
<td>YES</td>
<td>40%</td>
</tr>
<tr>
<td>Enteral formula delivered through a feeding tube</td>
<td>Must be sole source of nutrition.</td>
<td>20%</td>
<td>YES</td>
<td>40%</td>
</tr>
<tr>
<td>Enteral formula or food taken orally *</td>
<td></td>
<td>20%</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Hair Prosthesis (Wigs)</td>
<td>Benefit is limited to the maximum benefit of $350 per hair prosthesis (wig) when worn for hair loss suffered as a result of cancer treatment.</td>
<td>20%</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Service Type, Provider, or Place of Service</td>
<td>Benefit Limit</td>
<td>Network provider</td>
<td>Non-network provider</td>
</tr>
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</tr>
<tr>
<td>Early Intervention Services (EIS)</td>
<td>Early Intervention Services (EIS)</td>
<td>For children from birth to 36 months. The provider must be certified as an EIS provider by the Rhode Island Department of Human Services.</td>
<td>Your copayment: 0%</td>
<td>Your copayment: 0% The level of coverage is the same as network provider. NO</td>
</tr>
<tr>
<td>Education</td>
<td>Asthma Management</td>
<td></td>
<td>Does the deductible apply?: NO</td>
<td>Does the deductible apply?: NO</td>
</tr>
<tr>
<td>Experimental/Investigational Services</td>
<td></td>
<td></td>
<td>40%</td>
<td>YES</td>
</tr>
<tr>
<td>Hearing</td>
<td>Hearing Exam</td>
<td></td>
<td>$40</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>Diagnostic Testing</td>
<td></td>
<td>0%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>Hearing Aids</td>
<td>A maximum benefit of $1,500 per ear per hearing aid for a member under 19; A maximum benefit of $700 per ear per hearing aid for a member 19 and older.</td>
<td>20%</td>
<td>The level of coverage is the same as network provider.</td>
</tr>
<tr>
<td>Service</td>
<td>Service Type, Provider, or Place of Service</td>
<td>Benefit Limit</td>
<td>Your copayment</td>
<td>Does the deductible apply?</td>
</tr>
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</tr>
<tr>
<td>Hemophilia Services</td>
<td>Outpatient</td>
<td>Prescription drug coverage benefit level is based on type of service and site of service. See Summary of Pharmacy Benefits for details.</td>
<td>0%</td>
<td>YES</td>
</tr>
<tr>
<td>Homem Health Care</td>
<td>In your home</td>
<td>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 Summary of Pharmacy Benefits for details.</td>
<td>0%</td>
<td>YES</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Inpatient/in your home</td>
<td>When provided by an approved hospice care program. Prescription drug coverage benefit level is based on type of service and site of service. See Summary of Pharmacy Benefits for details.</td>
<td>0%</td>
<td>YES</td>
</tr>
<tr>
<td>Service</td>
<td>Service Type, Provider, or Place of Service</td>
<td>Benefit Limit</td>
<td>Network provider</td>
<td>Non-network provider</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For a covered health care service you pay:</td>
<td>For a covered health care service you pay the difference between the charge amount and the allowance plus:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Your copayment</td>
<td>Your copayment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Does the deductible apply?</td>
<td>Does the deductible apply?</td>
</tr>
<tr>
<td>Hospital Emergency Room Services</td>
<td>Hospital Emergency Room</td>
<td>See Section 8.0 – definition of Emergency.</td>
<td>$250</td>
<td>NO</td>
</tr>
<tr>
<td>Human Leukocyte Antigen Testing</td>
<td>Human Leukocyte Antigen Testing</td>
<td>0%</td>
<td>YES</td>
<td>40%</td>
</tr>
<tr>
<td>Infertility</td>
<td>Inpatient/ outpatient/in a doctor's office</td>
<td>Three (3) infertility treatment cycles will be covered per plan year with a total of eight (8) infertility treatment cycles covered in a member's lifetime.</td>
<td>20%</td>
<td>YES</td>
</tr>
</tbody>
</table>

Prescription drug coverage benefit level is based on type of service and site of service. See Summary of Pharmacy Benefits for details.
<table>
<thead>
<tr>
<th>Service</th>
<th>Service Type, Provider, or Place of Service</th>
<th>Benefit Limit</th>
<th>Network provider</th>
<th>Non-network provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infusion Therapy</td>
<td>Outpatient</td>
<td>Prescription drug coverage benefit level is based on type of service and site of service. See Summary of Pharmacy Benefits for details.</td>
<td><strong>0%</strong></td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>In the doctor’s office/in your home</td>
<td>Prescription drug coverage benefit level is based on type of service and site of service. See Summary of Pharmacy Benefits for details.</td>
<td><strong>0%</strong></td>
<td>YES</td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>Inpatient*</td>
<td>Unlimited days at general hospital or a specialty hospital.</td>
<td><strong>0%</strong></td>
<td>YES</td>
</tr>
<tr>
<td>Inpatient Physician Hospital Visits</td>
<td>Inpatient</td>
<td></td>
<td><strong>0%</strong></td>
<td>YES</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Facility</td>
<td>Inpatient*</td>
<td>Maximum of 45 days per plan year.</td>
<td><strong>0%</strong></td>
<td>YES</td>
</tr>
<tr>
<td>Office Visits (other than)</td>
<td>Allergist &amp; Dermatologist</td>
<td>$40</td>
<td>NO</td>
<td><strong>40%</strong></td>
</tr>
<tr>
<td>Service</td>
<td>Service Type, Provider, or Place of Service</td>
<td>Benefit Limit</td>
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<td>Non-network provider</td>
</tr>
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</tr>
<tr>
<td></td>
<td>For a covered health care service you pay:</td>
<td></td>
<td>Your copayment</td>
<td>Does the deductible apply?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$40</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>Hospital based clinic visits for adults</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>House Calls rendered by personal care physician</td>
<td>PCP practices with PCMH model of care.</td>
<td>$15</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PCP does NOT practice with PCMH model of care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>For a member under nineteen (19)</td>
<td>$15</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$15</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>For a member nineteen (19) and older</td>
<td>$25</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$25</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>House Calls rendered by Specialist</td>
<td></td>
<td>$40</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>Pediatric Clinic visit</td>
<td>PCP practices with PCMH model of care.</td>
<td>$15</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PCP does NOT practice with PCMH model of care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>For a member under nineteen (19)</td>
<td>$15</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$15</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>For a member nineteen (19) and older</td>
<td></td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
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<td>Benefit Limit</td>
<td>Network provider</td>
<td>Non-network provider</td>
</tr>
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<td></td>
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<td></td>
<td>For a covered health care service you pay:</td>
<td>For a covered health care service you pay the difference between the charge amount and the allowance plus:</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Your copayment</td>
<td>Does the deductible apply?</td>
</tr>
<tr>
<td><strong>Personal Care Physician (PCP)</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$15</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>PCP practices with PCMH model of care.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PCP does NOT practice with PCMH model of care.</td>
<td>$15</td>
<td>NO</td>
<td></td>
</tr>
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<td></td>
<td>For a member under nineteen (19)</td>
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<td></td>
<td>NO</td>
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<tr>
<td></td>
<td>For a member nineteen (19) and older</td>
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<td></td>
<td></td>
<td></td>
<td>NO</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Podiatrist Services</strong></td>
<td>Routine foot care is not covered.</td>
<td>$40</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td><strong>Specialist Visits</strong></td>
<td>Routine and non-routine visits.</td>
<td>$40</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td><strong>Organ Transplants</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physical/Occupational Therapy</strong></td>
<td>Outpatient hospital/In a doctor's/therapist's office</td>
<td>$25</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preauthorization is recommended for the eleventh (11th) and subsequent visits.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Covered health care services include rehabilitative and habilitative services.</td>
<td>$40</td>
<td>YES</td>
<td></td>
</tr>
</tbody>
</table>

SG OOE VB Gold (1-14)
<table>
<thead>
<tr>
<th>Service</th>
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<th>Non-network provider For a covered health care service you pay the difference between the charge amount and the allowance plus:</th>
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</thead>
<tbody>
<tr>
<td>Pregnancy Services and Nursery Care</td>
<td>Pre-natal, delivery, and postpartum services.</td>
<td></td>
<td>Your copayment</td>
<td>Does the deductible apply?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0%</td>
<td>YES</td>
<td>40%</td>
</tr>
<tr>
<td>Prescription drugs, other than Specialty Prescription drugs, dispensed and administered by a licensed health care provider (other than a pharmacist)</td>
<td>Medications other than injected and infused drugs.</td>
<td>Are included in the allowance for the medical service being rendered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injectable drugs</td>
<td></td>
<td>0%</td>
<td>YES</td>
<td>40%</td>
</tr>
<tr>
<td>Infused drugs</td>
<td></td>
<td>0%</td>
<td>YES</td>
<td>40%</td>
</tr>
<tr>
<td>Prescription Drugs Purchased at a Retail, Specialty, or Mail Order Pharmacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention and Early Detection Services</td>
<td>Adult annual preventive visit</td>
<td>One (1) routine adult physical examination per plan year per member will be covered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0%</td>
<td>NO</td>
<td>40%</td>
</tr>
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<td>Benefit Limit</td>
<td>Network provider</td>
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<td></td>
<td>Non-network provider</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>Your copayment</td>
<td>Does the deductible apply?</td>
</tr>
<tr>
<td>Well woman annual preventive visit</td>
<td>One (1) routine gynecological examination per plan year per female member will be covered.</td>
<td>0%</td>
<td>NO</td>
<td>40%</td>
</tr>
<tr>
<td>Pediatric preventive office visit</td>
<td>Well-Child Office Visits: Birth - 15 months: 8 visits; 16 - 35 months: 3 visits; 36 months - 19 years: 1 per plan year.</td>
<td>0%</td>
<td>NO</td>
<td>40%</td>
</tr>
<tr>
<td>Pediatric preventive clinic</td>
<td></td>
<td>0%</td>
<td>NO</td>
<td>40%</td>
</tr>
<tr>
<td>Diabetes education</td>
<td>Individual and group sessions are covered.</td>
<td>0%</td>
<td>NO</td>
<td>40%</td>
</tr>
<tr>
<td>Nutritional counseling</td>
<td>Unlimited visits per plan year when prescribed by a physician.</td>
<td>0%</td>
<td>NO</td>
<td>40%</td>
</tr>
<tr>
<td>Smoking cessation counseling</td>
<td>For nicotine replacement therapy (NRT) and smoking cessation prescription drugs, see the Summary of Pharmacy Benefits.</td>
<td>0%</td>
<td>NO</td>
<td>40%</td>
</tr>
<tr>
<td>Adult Immunization</td>
<td></td>
<td>0%</td>
<td>NO</td>
<td>40%</td>
</tr>
<tr>
<td>Pediatric Immunization</td>
<td></td>
<td>0%</td>
<td>NO</td>
<td>40%</td>
</tr>
<tr>
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<td></td>
<td></td>
<td>Your copayment</td>
<td>Does the deductible apply?</td>
</tr>
<tr>
<td>Travel Immunization</td>
<td></td>
<td></td>
<td>0%</td>
<td>NO</td>
</tr>
<tr>
<td>Allergy injections</td>
<td>Applies to injection only including administration.</td>
<td>0%</td>
<td>YES</td>
<td>40%</td>
</tr>
<tr>
<td>Preventive screenings</td>
<td>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, screening for gestational diabetes, and human papillomavirus.</td>
<td>0%</td>
<td>NO</td>
<td>40%</td>
</tr>
</tbody>
</table>

**Prevention and Early Detection Services**

<p>| Genetic Counseling for BRCA | Must be performed by a certified genetic counselor. | 0% | NO | 40% | YES |
| Contraceptive and Sterilization Services for women | Prescription drugs, dispensed and administered by a licensed health care provider (other than a pharmacist). For prescription drugs purchased at a pharmacy, see the Summary of Pharmacy Benefits. | 0% | NO | 40% | YES |</p>
<table>
<thead>
<tr>
<th>Service</th>
<th>Service Type, Provider, or Place of Service</th>
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<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Your copayment</td>
<td>Does the deductible apply?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Barrier method (cervical cap or diaphragm) fitted and supplied during an office visit.</td>
<td>0%</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Surgical services, including but not limited to, tubal ligation and insertion/removal of IUD.</td>
<td>0%</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>Manual breast pumps</td>
<td>In conjunction with birth.</td>
<td>0%</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>Private Duty Nursing*</td>
<td>Must be performed by a certified home health care agency.</td>
<td>0%</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>Radiation Therapy/Chemotherapy Services</td>
<td>Outpatient</td>
<td>0%</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In a doctor’s office</td>
<td>0%</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>Respiratory Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled Nursing Facility Care*</td>
<td>Skilled or Sub-acute</td>
<td>0%</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>Speech Therapy*</td>
<td>Outpatient/in a doctor’s/therapist’s office</td>
<td>Covered health care services include rehabilitative and habilitative services.</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>Surgery</td>
<td>Inpatient</td>
<td>0%</td>
<td>YES</td>
</tr>
<tr>
<td>Service</td>
<td>Benefit Limit</td>
<td>Network provider</td>
<td>Non-network provider</td>
<td></td>
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<tr>
<td></td>
<td>Your copayment</td>
<td>Does the deductible apply?</td>
<td>Your copayment</td>
<td>Does the deductible apply?</td>
</tr>
<tr>
<td>Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>0%</td>
<td>YES</td>
<td>40%</td>
<td>YES</td>
</tr>
<tr>
<td>In a doctor’s office</td>
<td>0%</td>
<td>NO</td>
<td>40%</td>
<td>YES</td>
</tr>
<tr>
<td>Tests, Imaging*, and Labs (includes machine tests and x-rays)</td>
<td>Applies to the following diagnostic imaging services:</td>
<td>Preauthorization is recommended for these diagnostic imaging services.</td>
<td>For tests, imaging and lab, other than the diagnostic imaging services listed above.</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital Facility/</td>
<td>0%</td>
<td>YES</td>
<td>40%</td>
<td>YES</td>
</tr>
<tr>
<td>Outpatient Non-Hospital facility including in a Doctor’s office, urgent care center, or free-standing laboratory</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Your copayment</td>
<td>Does the deductible apply?</td>
</tr>
<tr>
<td>Diagnostic colorectal services</td>
<td>Including, but not limited to, fecal occult blood testing, flexible sigmoidoscopy, colonoscopy, and barium enema. See Prevention and Early Detection Services - Preventive Screening for preventive colorectal services.</td>
<td></td>
<td>0%</td>
<td>YES</td>
</tr>
<tr>
<td>Lyme Disease-Diagnosis/Treatment</td>
<td></td>
<td></td>
<td>0%</td>
<td>YES</td>
</tr>
<tr>
<td>Urgent care facility</td>
<td>Urgent care facility/walk-in</td>
<td>See Section 8.0 - definition of urgent care center.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$75</td>
<td>NO</td>
</tr>
</tbody>
</table>

The level of coverage is the same as network provider.
### Vision care services

**In a doctor’s office**

- **Benefit Limit**: One routine eye exam per plan year, including one pediatric vision exam for a member up to age 19. *Medically necessary eye exams are covered.*

<table>
<thead>
<tr>
<th>Network provider</th>
<th>Non-network provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For a covered health care service you pay:</strong></td>
<td><strong>For a covered health care service you pay the difference between the charge amount and the allowance plus:</strong></td>
</tr>
<tr>
<td>Your copayment</td>
<td>Your copayment</td>
</tr>
<tr>
<td>Does the deductible apply?</td>
<td>Does the deductible apply?</td>
</tr>
</tbody>
</table>

- **Network provider**
  - **Your copayment**: $40
  - **Does the deductible apply?**: NO

- **Non-network provider**
  - **Your copayment**: 40%
  - **Does the deductible apply?**: YES

**Vision Hardware for a member aged 19 and older**

- **Benefit Limit**: Not Covered

**Vision Hardware for a member under the age of 19**

- **Benefit Limit**: One pair of collection prescription frames per plan year.
  - Non-collection prescription frames are NOT covered.

<table>
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</tr>
</thead>
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</tr>
<tr>
<td>Your copayment</td>
<td>Your copayment</td>
</tr>
<tr>
<td>Does the deductible apply?</td>
<td>Does the deductible apply?</td>
</tr>
</tbody>
</table>

- **Network provider**
  - **Your copayment**: 0%
  - **Does the deductible apply?**: NO

- **Non-network provider**
  - **Your copayment**: Not Covered
  - **Does the deductible apply?**: Not Covered
<table>
<thead>
<tr>
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<td>For a covered health care service you pay:</td>
<td>Your copayment</td>
<td>Does the deductible apply?</td>
<td>Your copayment</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>One pair of glass or plastic lenses per plan year.</td>
<td>0%</td>
<td>NO</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>This includes single vision, bifocal, trifocal, lenticular, and standard progressive lens.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>The following lens treatments are covered:</td>
<td>$0</td>
<td>NO</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>• UV treatment;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Tint (fashion, gradient, and glass-grey)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Standard plastic scratch coating;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Standard polycarbonate;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Photocromatic/transitions plastic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>One supply of collection contact lenses (Extended Wear OR Daily Wear OR Conventional) covered in lieu of Prescription Glasses. Includes evaluation, fitting or follow-up care relating to contact lenses.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Subscriber Agreement

<table>
<thead>
<tr>
<th>Service</th>
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<td></td>
<td></td>
<td></td>
<td>Your copayment</td>
<td>Does the deductible apply?</td>
</tr>
<tr>
<td>Non-collection contact lenses are NOT covered.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Extended Wear Disposables are covered up to the benefit limit of a six (6) month supply of monthly or two (2) week disposables in a plan year</td>
<td></td>
<td></td>
<td>0%</td>
<td>NO</td>
</tr>
<tr>
<td>• Daily Wear Disposable are covered up to the benefit limit of a three (3) month supply of daily disposable lenses in a plan year</td>
<td></td>
<td></td>
<td>0%</td>
<td>NO</td>
</tr>
<tr>
<td>• Conventional contact lens are covered one per plan year</td>
<td></td>
<td></td>
<td>0%</td>
<td>NO</td>
</tr>
<tr>
<td>One additional supply (as indicated above) of contact lenses may be covered for certain conditions:</td>
<td></td>
<td></td>
<td>0%</td>
<td>NO</td>
</tr>
<tr>
<td>Service</td>
<td>Benefit Limit</td>
<td>Network provider</td>
<td>Non-network provider</td>
<td></td>
</tr>
<tr>
<td>---------</td>
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<td>------------------</td>
<td>---------------------</td>
<td></td>
</tr>
<tr>
<td>Service Type, Provider, or Place of Service</td>
<td>For a covered health care service you pay:</td>
<td>For a covered health care service you pay the difference between the charge amount and the allowance plus:</td>
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</tr>
<tr>
<td></td>
<td>Your copayment</td>
<td>Does the deductible apply?</td>
<td>Your copayment</td>
<td>Does the deductible apply?</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td></td>
<td>· Anisometropia</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>· High Ametroplia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Keratoconus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Vision improvement for members whose vision can be corrected two lines of improvement.</td>
<td>Preauthorization recommended.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SUMMARY OF PHARMACY BENEFITS

Only applies to the Summary of Pharmacy Benefits

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

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

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

Prescription drugs in our formulary are placed into the following tiers, or levels, for copayment purposes:

Tier 1 – generally low cost preferred generic drugs which require the lowest copayment;
Tier 2 – generally includes other certain formulary low cost preferred generic prescription drugs, which require a higher copayment than the First Tier.
Tier 3 – generally includes formulary high cost non-preferred generic prescription drugs and preferred brand name prescription drugs, which require a higher copayment.
Tier 4 – generally includes other formulary generic and non-preferred brand name drugs which require a higher copayment than the Third Tier.
Tier 5 – 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. To obtain a copy of the most current formulary listing, visit our Web site at BCBSRI.com or you may call our Customer Service Department at (401) 459-5000 or 1-800-639-2227.

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

Note: To find out what tier a prescription drug is, call our Customer Service Department at (401) 274-3500 or 1-800-564-0888.
<table>
<thead>
<tr>
<th>Type and Site of Service</th>
<th>Benefit Limit/Notes</th>
<th>Tier</th>
<th>Network pharmacy</th>
<th>Non-network pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>For a covered health care service you pay:</td>
<td>For a covered health care service you pay the difference between the charge amount and the allowance plus:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Your copayment</td>
<td>Does the deductible apply?</td>
</tr>
<tr>
<td>Prescription Drugs, other than Specialty Prescription Drugs</td>
<td>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.</td>
<td>Tier 1</td>
<td>$3</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 2</td>
<td>$12</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 3</td>
<td>$35</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 4</td>
<td>$60</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 5</td>
<td></td>
<td>See specialty prescription drug section below.</td>
</tr>
<tr>
<td></td>
<td>• when purchased at a Retail or Specialty Pharmacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Up to a 90-day supply of maintenance and non-maintenance prescription drugs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>You are responsible to</td>
<td>Tier 1</td>
<td>$7.50</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 2</td>
<td>$30</td>
<td>NO</td>
</tr>
<tr>
<td>Type and Site of Service</td>
<td>Benefit Limit/Notes</td>
<td>Tier</td>
<td>Network Pharmacy</td>
<td>Non-network Pharmacy</td>
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<td></td>
<td>For a covered health care service you pay:</td>
<td>For a covered health care service you pay the difference between the charge amount and the allowance plus:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Your copayment</td>
<td>Does the deductible apply?</td>
</tr>
<tr>
<td>Tier 3</td>
<td>$87.50</td>
<td>NO</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Tier 4</td>
<td>$150</td>
<td>NO</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Tier 5</td>
<td>See specialty prescription drug section below.</td>
<td>See specialty prescription drug section below.</td>
<td>See specialty prescription drug section below.</td>
<td>See specialty prescription drug section below.</td>
</tr>
<tr>
<td>Infertility Prescription drugs, other than Infertility Specialty Prescription Drugs</td>
<td>Limited to married female members aged 25 to 42. Three (3) infertility treatment cycles will be covered per plan year with a total of eight (8) infertility</td>
<td>Tier 1</td>
<td>20%</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 2</td>
<td>20%</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 3</td>
<td>20%</td>
<td>NO</td>
</tr>
<tr>
<td>Type and Site of Service</td>
<td>Benefit Limit/Notes</td>
<td>Tier</td>
<td>Network pharmacy For a covered health care service you pay:</td>
<td>Non-network pharmacy For a covered health care service you pay the difference between the charge amount and the allowance plus:</td>
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<td>------------------------------------------------------------------------------------</td>
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<td>------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Mail Order Pharmacy</td>
<td>treatment cycles covered in a member’s lifetime.</td>
<td>Tier 4</td>
<td>20%</td>
<td>Your copayment</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Tier 5</td>
<td>See specialty prescription drug section below.</td>
<td>See specialty prescription drug section below.</td>
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<tr>
<td>Contraceptive methods</td>
<td>Coverage includes barrier method (diaphragm or cervical cap), hormonal method (birth control pill), and emergency contraception. Copayment applies per each 30-day supply or portion thereof of maintenance and non-maintenance prescription drugs. You are responsible to</td>
<td>Tier 1</td>
<td>0%</td>
<td>NO</td>
</tr>
<tr>
<td>when purchased at a Retail or Specialty Pharmacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 2</td>
<td>$12</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Tier 3</td>
<td>$35</td>
<td>NO</td>
</tr>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 4</td>
<td>$60</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 5</td>
<td>Contraceptives are only placed in Tier 1, Tier 2, Tier 3, or Tier 4. See above.</td>
<td></td>
</tr>
</tbody>
</table>

Subscriber Agreement
<table>
<thead>
<tr>
<th>Type and Site of Service</th>
<th>Benefit Limit/Notes</th>
<th>Tier</th>
<th>Network pharmacy</th>
<th>Non-network pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>For a covered health care service you pay:</td>
<td>For a covered health care service you pay the difference between the charge amount and the allowance plus:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Your copayment</td>
<td>Does the deductible apply?</td>
</tr>
<tr>
<td>Contraceptive methods</td>
<td>Coverage includes barrier method (diaphragm or cervical cap), hormonal method (birth control pill), and emergency contraception. 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.</td>
<td>Tier 1</td>
<td>0%</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 2</td>
<td>$30</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 3</td>
<td>$87.50</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 4</td>
<td>$150</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type and Site of Service</td>
<td>Benefit Limit/Notes</td>
<td>Tier</td>
<td><strong>Network pharmacy</strong> For a covered health care service you pay:</td>
<td><strong>Non-network pharmacy</strong> For a covered health care service you pay the difference between the charge amount and the allowance plus:</td>
</tr>
<tr>
<td>--------------------------</td>
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<td>-------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Over-the-counter (OTC) preventive drugs, purchased at any pharmacy</td>
<td>Must be prescribed by a physician. See Pharmacy Benefits for details.</td>
<td>Tier 1</td>
<td>0%</td>
<td>NO</td>
</tr>
<tr>
<td>Diabetes, Asthma, and COPD prescription drugs</td>
<td>Member must be being treated for certain health conditions</td>
<td>Tier 2</td>
<td>$2</td>
<td>NO</td>
</tr>
<tr>
<td>NRT and Smoking Cessation Prescription Drugs, purchased at a Retail or Specialty Pharmacy.</td>
<td>Must be prescribed by a physician. See Pharmacy Benefits for details. Nicotine replacement therapy and smoking cessation prescription drugs are not covered when purchased at a mail order pharmacy.</td>
<td>Tier 3</td>
<td>$35</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 4</td>
<td>$60</td>
<td>NO</td>
</tr>
<tr>
<td>Type and Site of Service</td>
<td>Benefit Limit/Notes</td>
<td>Tier</td>
<td><strong>Network pharmacy</strong>&lt;br&gt;For a covered health care service you pay:</td>
<td><strong>Non-network pharmacy</strong>&lt;br&gt;For a covered health care service you pay the difference between the charge amount and the allowance plus:</td>
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<td>---------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 5</td>
<td>Your copayment</td>
<td>Your copayment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Does the deductible apply?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>YES</td>
</tr>
<tr>
<td>Specialty Prescription Drugs</td>
<td></td>
<td>Tier 5</td>
<td>$100</td>
<td>50%</td>
</tr>
<tr>
<td>when purchased at a Specialty Pharmacy(+)</td>
<td>Copayment applies per each 30-day supply or applies per recommended treatment interval.</td>
<td>Tier 5</td>
<td>You are responsible to pay the lower of your copayment or the retail price of the drug.</td>
<td>YES</td>
</tr>
<tr>
<td>when purchased at a Retail Pharmacy(+)</td>
<td>Specialty Prescription Drugs purchased at a Retail Pharmacy are reimbursed at the non-network level of coverage.</td>
<td>Tier 5</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
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<td></td>
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<td></td>
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<td></td>
<td></td>
<td>YES</td>
</tr>
</tbody>
</table>

NRT and Smoking Cessation drugs are only placed in Tier 1, Tier 2, Tier 3, or Tier 4. See above.
<table>
<thead>
<tr>
<th>Type and Site of Service</th>
<th>Benefit Limit/Notes</th>
<th>Tier</th>
<th>Network pharmacy</th>
<th>Non-network pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>when purchased at a Mail Order Pharmacy (+)</td>
<td></td>
<td>Tier 5</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Infertility specialty prescription drugs purchased at a Specialty Pharmacy (+)</td>
<td>Three (3) infertility treatment cycles will be covered per plan year with a total of eight (8) infertility treatment cycles covered in a member’s lifetime.</td>
<td>Tier 5</td>
<td>20% * Your copayment is based on the lower of the pharmacy allowance or the retail cost of the prescription drug.</td>
<td>20% * Our reimbursement is based on the pharmacy allowance. You are responsible to pay up to the retail cost of the drug.</td>
</tr>
<tr>
<td>Infertility specialty prescription drugs purchased at a Retail Pharmacy (+)</td>
<td>Specialty Prescription Drugs purchased at a Retail Pharmacy are reimbursed at the non-network level of coverage. Three (3) infertility treatment cycles will be covered per plan year with a total of eight (8) infertility</td>
<td>Tier 5</td>
<td>20% * Our reimbursement is based on the pharmacy allowance. You are responsible to pay up to the retail cost of the drug.</td>
<td>20% * Our reimbursement is based on the pharmacy allowance. You are responsible to pay up to the retail cost of the drug.</td>
</tr>
</tbody>
</table>
## Summary of Benefits

### Type and Site of Service

<table>
<thead>
<tr>
<th>Benefit Limit/Notes</th>
<th>Tier</th>
<th>Network pharmacy</th>
<th>Non-network pharmacy</th>
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<tr>
<td></td>
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<td>For a covered health care service you pay:</td>
<td>For a covered health care service you pay the difference between the charge amount and the allowance plus:</td>
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<tr>
<td></td>
<td></td>
<td>Your copayment</td>
<td>Does the deductible apply?</td>
</tr>
<tr>
<td>Diabetic equipment and supplies</td>
<td>Tier 1</td>
<td>$3</td>
<td>NO</td>
</tr>
<tr>
<td>when purchased at a Retail or Specialty Pharmacy</td>
<td>Tier 2</td>
<td>$12</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>$35</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>Tier 4</td>
<td></td>
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</table>
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<table>
<thead>
<tr>
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<th>Benefit Limit/Notes</th>
<th>Tier</th>
<th><strong>Network pharmacy</strong></th>
<th>Does the deductible apply?</th>
<th><strong>Non-network pharmacy</strong></th>
<th>Your copayment</th>
<th>Does the deductible apply?</th>
</tr>
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<tr>
<td></td>
<td></td>
<td></td>
<td>For a covered health care service you pay:</td>
<td>Your copayment</td>
<td>For a covered health care service you pay the difference between the charge amount and the allowance plus:</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>Your copayment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 1</td>
<td>$7.50</td>
<td>NO</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 2</td>
<td>$30</td>
<td>NO</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 3</td>
<td>$87.50</td>
<td>NO</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Tier 4</td>
<td></td>
<td></td>
<td>Diabetic equipment and supplies are only placed in Tier 1, Tier 2, or Tier 3. See above.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Your copayment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.
<table>
<thead>
<tr>
<th>Type and Site of Service</th>
<th>Benefit Limit/Notes</th>
<th>Tier</th>
<th><strong>Network pharmacy</strong> For a covered health care service you pay:</th>
<th><strong>Non-network pharmacy</strong> For a covered health care service you pay the difference between the charge amount and the allowance plus:</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Your copayment</strong></td>
<td><strong>Your copayment</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Does the deductible apply?</strong></td>
<td><strong>Does the deductible apply?</strong></td>
</tr>
<tr>
<td>Prescription drugs, other than Specialty Prescription Drugs, dispensed and administered by a licensed health care provider (other than a pharmacist).</td>
<td>See the Summary of Medical Benefits.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Subscriber Agreement**

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SG OOE VB Gold (1-14)

34
# Blue Cross & Blue Shield of Rhode Island
## SUBSCRIBER AGREEMENT

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1.0 INTRODUCTION

1.1 Agreement and Its Interpretation
Our entire contract with you consists of this agreement and our agreement with your employer/agent. A determination will be made regarding your eligibility for benefits and the provisions of this agreement will be construed subject to your right to appeal or to take legal action as described in Section 7.0.

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

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

1.2 How to Find What You Need to Know in this Agreement
The Summary of Benefits at the front of this agreement will show you:
- what health care services are covered under this agreement;
- any benefit limits, copayments and deductibles you must pay; and
- services for which preauthorization or predetermination is recommended or required.

The Table of Contents will help you find the order of the sections, as they appear in the agreement:
- Section 1.0 - important introductory information;
- Section 2.0 - information about eligibility;
- Section 3.0 - covered health care services;
- Section 4.0 - health care services which are not covered under this agreement;
- Section 5.0 - how we pay for your covered health care services;
- Section 6.0 - how we coordinate benefits when you are covered by more than one plan;
- Section 7.0 - how to file a claim and how to appeal a claim; and
- Section 8.0 - words with special meaning.

1.3 Words With Special Meaning
Some words and phrases used in this agreement are in italics. This means that the words or phrases have a special meaning as they relate to your health care coverage. Section 8.0 – Glossary defines many of these words.

The sections below also define certain words and phrases:
• Section 3.0 - Covered Health Care Services;
• Section 6.0 - How We Coordinate Your Benefits When You Are Covered By More Than One Plan;
• Section 7.0 - How To File And Appeal A Claim; and
• Section 7.7 - Our Right of Subrogation and Reimbursement.

1.4 You and Blue Cross & Blue Shield of Rhode Island

We, Blue Cross & Blue Shield of Rhode Island, agree to provide coverage for medically necessary covered health care services listed in this agreement. (The term medically necessary is defined in Section 8.0) 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.

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.

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 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.

Genetic Information
This agreement does not limit your coverage based on genetic information.

We will not:
• adjust premiums based on genetic information;
• request or require an individual or family members of an individual to have a genetic test; or
• collect genetic information from an individual or family members of an individual before or in connection with enrollment under this agreement or at any time for underwriting purposes.

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

Below are a few examples of when you should call our Customer Service Department:
• To learn if a provider participates with Blue Cross & Blue Shield of Rhode Island’s designated BlueCard PPO network;
• To learn if a dental provider participates in our local dental network;
• To learn about EyeMed Vision Care;
• To ask questions and get information about your coverage;
• To file a complaint or administrative appeal (See Section 7.2);
• To file an appeal about a medical necessity determination or learn about the status of your appeal (See Section 7.3); or
• To ask for a HIPAA (Health Insurance Portability and Accountability Act) certificate of creditable coverage (See Section 2.4-When Your Coverage Ends).

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

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

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

1.6 Preauthorization

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

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

If you are responsible for obtaining preauthorization, we will send to you notification of the preauthorization determination within fourteen (14) calendar days from receipt of the request or prior to the date of service. Please see Section 8.0 for the definition of preauthorization.

Expedited Preauthorization Review

You may request an expedited preauthorization review if the circumstances are an emergency. If an expedited preauthorization review is received by us, we will respond to you with a determination within seventy two (72) hours or in less than seventy two (72) hours (taking into consideration medical exigencies) 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) 459-5000 or 1-800-639-2227 or visit our Web site at BCBSRI.com to see if a prescription drug requires prescription drug preauthorization. Prescription drug preauthorization is defined in Section 3.27.
1.7 **Our Right to Receive and Release Information About You**

We are committed to maintaining the confidentiality of your health care information. However, in order for us to make available quality, cost-effective health care coverage to you, we may release and receive information about your health, treatment, and condition to or from authorized providers and insurance companies, among others. We may give or get this information, as permitted by law, for certain purposes, including, but not limited to:

- adjudicating health insurance claims;
- administration of claim payments;
- health care operations;
- case management and utilization review; and
- coordination of health care benefits.


1.8 **Participation in Our Wellness Incentive Programs**

Our Wellness Programs are designed to promote good health and prevent disease.

Participation in our Wellness Programs is voluntary. If you choose to participate, you may receive rewards, such as a reduction or waiver of copayments for certain covered health care services. We may require you to sign a pledge or letter of agreement to acknowledge participation in the Wellness Programs. Your signature will document your willingness to voluntarily participate and your acknowledgement of the Wellness Program requirements that must be met in order to receive the reward. We may not make Wellness Programs available to all members or to any member a second time. We reserve the right to terminate Wellness Programs at any time.

We will contact you directly if you are eligible for one of our Wellness Programs. You may obtain a current list of our Wellness Programs by visiting our Web site at BCBSRI.com or contacting our Customer Service Department.

1.9 **Our Right to Conduct Utilization Review**

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

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

Although we may conduct utilization review, Blue Cross & Blue Shield of Rhode Island does not act as a health care provider. We do not furnish medical care. We do not make medical judgments. You are not prohibited from having a treatment or hospitalization for which reimbursement has been denied. Nothing here will change or affect your relationship with your provider(s).

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

We review claims for payment to determine if the claims:
• were properly authorized;
• constitute medically necessary services for the purpose of benefit payment; and
• are covered health care services under this agreement.

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

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

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

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

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

Your employer may purchase this agreement directly from us or from the HealthSource RI.

If you purchased this agreement from us, 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.

If purchased from HealthSource RI, eligibility determinations will be made by your employer and HealthSource RI. Please contact your employer or HealthSource RI at 1-855-683-6759 for questions about your eligibility.

2.1 Who is an Eligible Person

You: You are eligible to enroll in coverage under this agreement provided that you:
• meet the minimum work-hour requirements; and
• have satisfied the waiting period, if any, of your employer/agent.

The date on which you have met your employer’s/agent’s eligibility requirements and are entitled to apply for coverage under this agreement is your eligibility date.

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.

• Domestic Partner: Provided your employer/agent authorizes the eligibility of domestic partners, 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. Please contact your employer/agent for additional information regarding coverage for domestic partners.

• 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.

Your Children: Each of your and your spouse’s children is eligible for coverage as ordered by a Qualified Medical Child Support Order (“QMCSO”) or until the first day of the month following their 26th birthday. 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 age limit age of twenty-six (26) and is no longer considered eligible for coverage, he or she continues to be an eligible person under this agreement if the eligible person under this agreement 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.

2.2 When Your Coverage Begins

When You Can Enroll or Make Changes

When you are first eligible, you and your eligible dependents may enroll by completing an application through your employer/agent within the first thirty-one (31) following your eligibility date. 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 eligibility date.

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

Open Enrollment Period

An Open Enrollment Period will be held each year for coverage to be effective on the first day of the plan year. You and/or your eligible dependents may enroll at this time by completing an application during the open enrollment period.

Special Enrollment Period

After your initial effective date, you may enroll your eligible dependents for coverage through a Special Enrollment Period by completing an application within thirty (30) days following the Special Enrollment 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.

If you lose your private health insurance coverage, you may enroll or add your eligible dependents for coverage through a Special Enrollment Period by completing a written application within thirty (30) days following the Special Enrollment event. Coverage will begin on the first day of the month following the event. You and/or your eligible dependents will qualify for a Special Enrollment Period as follows:

• The eligible person seeking coverage had other coverage at the time that he or she was first eligible for coverage under this agreement; and the coverage on the other plan is terminated as a result of loss of eligibility for coverage because of the following:
  • legal separation or divorce,
  • death of the covered individual,
  • termination of employment or reduction in the number of hours of employment.
• the covered individual’s becoming entitled to Medicare,
• loss of dependent child status under the plan,
• employer contributions to such coverage is being terminated,
• COBRA benefits are exhausted, or
• your employer is undergoing Chapter 11 proceedings.

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, under your employer/agent’s coverage, through Medicaid or CHIP.

In addition, you may also be eligible for the following Special Enrollment periods if you apply within thirty (30) days following the Special Enrollment event:

- if you or your dependent lose minimum essential coverage, coverage begins the first day of the following month;
- you adequately demonstrate to us that we substantially violated a material provision of our agreement with you coverage begins
  - the first of the following month, if your application is received between 1st and 15th day of the month;
  - the first of the second following month, if your application is received between the 16th and last day of the month

- you make a permanent move into the service area coverage begins:
  - the first of the following month, if your application is received between 1st and 15th day of the month
  - the first of the second following month, if your application is received between the 16th and last day of the month

- your enrollment or non-enrollment in a qualified health plan (QHP) is unintentional, inadvertent, or erroneous and is the result of error, misrepresentation, or inaction of us, HealthSource RI, or the U.S. Department of Health and Human Services (HHS)
  - the first of the following month, if your application is received between 1st and 15th day of the month
  - the first of the second following month, if your application is received between the 16th and last day of the month

If purchased from HealthSource RI, you may also be eligible for the following additional special enrollment periods. Please contact HealthSource RI, at 1-855-683-6759 for questions about these special enrollment periods and your eligibility within thirty (30) days following the Special Enrollment event.
• If you are an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, you may enroll or change from one
coverage to another one time per month, coverage begins
  • the first of the following month, if your application is received between 1st and 15th day of the month;
  • the first of the second following month, if your application is received between the 16th and last day of the month.
• If you demonstrate to HealthSource RI, in accordance with guidelines issued by Health and Human Services, that you meet
other exceptional circumstances, coverage begins:
  • the first of the following month, if your application is received between 1st and 15th day of the month;
  • the first of the second following month, if your application is received between the 16th and last day of the month.

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

2.3 How to Add or Remove Coverage for Family Members
You must notify your employer/agent 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 notify your employer/agent in advance of the requested
removal date and your employer/agent must send notification to us.

2.4 When Your Coverage Ends
When We End This Agreement

Coverage under this agreement is guaranteed renewable. It can be canceled for the following reasons.

This agreement will end:
  • if you leave your place of work;
  • if you decide to discontinue coverage, we, your employer/agent, or HealthSource RI must receive notice to end this
agreement fourteen (14) prior to the requested date of cancellation. If we do not receive your notice prior to the
requested date of cancellation, you or your employer/agent may be responsible for paying another month’s membership
fees;
• if you or your employer/agent does not pay any required membership fees within one month of the date they are due. If your employer/agent does not pay the required fees, the termination will be effective five (5) days after we mail you a notice of discontinuance;
• if you cease to be an eligible person;
• if we cease to offer this type of coverage;
• for a covered dependent if the dependent no longer qualifies as an eligible dependent.
• if your employer/agent contracts with another insurer or entity to provide or administer benefits for the covered health care services provided by this agreement, your group’s agreement with us will end.
• if fraud is determined by us. Fraud includes, but is not limited to, misuse of your identification card (ID card) and any misrepresentation made by you, or on your behalf, that affects your coverage. Fraud may result in retroactive termination. You will be responsible for all costs incurred by Blue Cross & Blue Shield of Rhode Island due to the fraud. Blue Cross & Blue Shield of Rhode Island may decline reinstatement under your group coverage, or any other coverage that may become available in the future; or
• if abuse or disregard for provider protocols and policies is determined by us. If after making a reasonable effort physicians are unable to establish or maintain a satisfactory relationship with a member, coverage may be terminated after 31-days’ written notice. Examples of unsatisfactory physician-patient relationships include:
  • abusive or disruptive behavior in a physician’s office;
  • repeated refusals by a member to accept procedures or treatment recommended by a physician; and
  • impairing the ability of the physician to provide care.

If you purchase coverage from HealthSource RI and the Qualified Health Plan is terminated or decertified, coverage under this agreement will end.

If we, for one of the reasons listed above, terminate this agreement, we must send to you a termination notice thirty (30) days before the termination date. The notice will indicate the reason why the agreement ended.

When your coverage ends, you will be entitled to apply for direct pay membership from Blue Cross & Blue Shield of Rhode Island or through the RI Health Benefit Exchange. You must meet the eligibility requirements. We must receive an application and membership fees within sixty (60) days from the date your group membership ends. If you do not reside in Rhode Island, you do not qualify to enroll in our direct pay plans. You may be able to obtain coverage through an insurance company in the state in which you reside.

**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.

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

**Retroactive Cancellations**
Rescind/Rescission means a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation is not a 
rescission if it:

- only has a prospective effect (as described above); or
- applies retroactively to the extent that such cancellation is due to the failure to timely pay premiums.

We may rescind your coverage if you or your dependents commit fraud. Fraud includes, but is not limited to, intentional misuse 
of your identification card (ID card) or intentional misrepresentation of material fact. Any benefit paid in the past will be voided. 
You will be responsible to reimburse us for all costs and claims paid by us. We must provide you a written notice of a rescission 
at least 30 days in advance. This notice will provide you the opportunity to appeal this decision. Please see Section 7.0 – How to 
File and Appeal a Claim.

Except for fraud and non-payment, we will not contest this policy after it has been in force for a period of two years from the later 
of the agreement effective date or latest reinstatement date.

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

**Continuation of Coverage According to State Law**
If your employment is terminated because of involuntary layoff or death, or as a result of the workplace ceasing to exist, or the 
permanent reduction in size of the workforce, the benefits of this agreement may be continued in accordance with Rhode Island 
General Laws c. 27-19.1, provided that you continue to pay the applicable premiums. The period of this continuation will be for 
up to eighteen (18) months from your termination date, but in any event not to exceed the shorter of the period which represents 
the period of continuous employment preceding termination with your employer. The continuation period will end for any person 
covered under your policy on the date such person becomes employed by another group and eligible for benefits under another 
group plan.

**Extended Benefits**
If you are totally disabled on the day your employer/agent’s 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.

Continuation of Coverage According to Federal Law
If coverage under this agreement for you or your covered dependents is terminated and your coverage was made available
through the group health plan of an employer/agent of 20 or more employees, you may continue to be eligible for coverage
according to federal law. This law is the Consolidated Omnibus Budget Reconciliation Act of 1986 as amended from time to time
(“COBRA”). Your employer/agent is responsible for making COBRA coverage available to you, and for complying with all of
COBRA’s requirements. The information provided below is a general summary of the COBRA requirements in place when this
agreement was drafted and should not be relied upon when making coverage decisions. You should contact your
employer/agent if you have any questions about COBRA.

Qualifying Events: In order to be eligible for COBRA continuation, you need to have experienced a Qualifying Event. A
Qualifying Event is one of the events listed below which would result in loss of coverage if not for the COBRA continuation:
(a) The death of the covered employee.
(b) The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered
employee's employment.
(c) The divorce or legal separation of the covered employee from the employee's spouse.
(d) The covered employee becoming entitled to benefits under (enrolled in) Medicare.
(e) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.
(f) A bankruptcy proceeding with respect to the employer/agent from whose employment the covered employee retired at
any time. In the case of a bankruptcy, a loss of coverage includes a substantial elimination of coverage within one year
before or after the date of commencement of the proceeding.
(g) Employees who leave civilian employment positions to perform active duty military service in the United States Uniformed
Services.

Election: If you are eligible for COBRA continuation and you experience a Qualifying Event, you must make an election with
your employer/agent for COBRA continuation coverage to begin. Your employer/agent will contact you and provide you with an
opportunity to elect COBRA continuation if you would lose coverage due to (a), (b), (d), or (f) above. If you experience the event
listed in (c), (e), or (g) you must notify your employer/agent within 60 days in order for your employer/agent to send election
forms.
Premium: You must pay premiums in order to continue to be covered. COBRA continuation coverage is generally at 102% of the applicable premium, or 150% of the applicable premium during the period of extended continuation due to disability as described below. Your employer/agent will notify you of the specific applicable premium.

Duration of Coverage: COBRA continuation may continue until the earlier of the following events:
1. The date on which the maximum period of coverage is exhausted. The maximum periods of coverage are:
   • 18 Months if COBRA continuation is available due to Qualifying Event (b).
   • 24 months while serving active duty military service if COBRA continuation is available due to Qualifying Event (g).
   • 36 Months if COBRA continuation is available due to Qualifying Events (a), (c), (d), (e), or (f).
   • Extension for disability: In the case you or one of your dependents is determined, under title II or XVI of the Social Security Act, to have been disabled at any time during the first 60 days of continuation coverage, the maximum period may be extended from 18 months to 29 months (with respect to you and all of your covered dependents). To qualify for this extension you must provide a copy of the Social Security ruling letter to the employer/agent within 60 days of receipt, but prior to the expiration of the 18 months.
2. The date on which the employer/agent ceases to provide any group health plan to any employee.
3. The date on which coverage ceases due to the failure to pay any required premium when due.
4. The date on which the covered person becomes covered on another group health plan that does not contain a pre-existing conditions clause for which the covered person does not have sufficient creditable coverage.
5. The date on which the covered person becomes entitled to (enrolled in) Medicare coverage.
6. In the event coverage is extended for up to 29 months due to disability, the first day of the month during such period of extension in which the covered person is determined to no longer be disabled.

If you have any questions regarding COBRA continuation, you are encouraged to contact your employer/agent.
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 hospital;
- 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 plan year maximum out-of-pocket expense;
- there are any exclusions from coverage that apply; or
- our allowance for a covered health care service is less than the amount of your copayment and deductible (if any). In this case, you will be responsible to pay up to our allowance when services are rendered by a network provider.

Please see the Summary of Medical Benefits to determine the benefit limits and amount that you pay for the covered health care services listed below.

Please see the Summary of Pharmacy Benefits to determine the benefit limits and amount that you pay for prescription drug and diabetic equipment and supplies purchased at a pharmacy.

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 listed in the Summary of Medical 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 *hospital* admission;
- from a *hospital* to home or to a skilled nursing facility or to a rehabilitation facility after being discharged as an *hospital*;
- 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 *hospital*; 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 Medical Benefits.

*Medically necessary* air and water ambulance services are covered up to the *maximum benefit limit* as 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 substance abuse disorder.

For the purposes of this agreement mental health disorder shall be defined as mental illness. 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.

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

Financial requirements (such as deductibles or copayments) or quantitative treatment limits (such as visit benefit limits) that apply to behavioral health services within a category (such as inpatient services received from an network provider) are not more restrictive than the benefit limit that applies to most of the medical benefits within that same category.
This *agreement* applies different levels of financial requirements to different tiers of prescription drug without regard to whether a prescription drug is generally prescribed for physical or mental health and/or *substance abuse* disorders. These factors include cost, efficacy, generic versus brand name, and mail order versus retail pharmacy pick-up. See Section 3.27 - Prescription Drugs.

The *agreement* may impose a variety of limits affecting the scope or duration of *benefits* that are not expressed numerically. An example of these types of treatments limit is *preauthorization*. *Preauthorization* is applied to behavioral health services in the same way as medical *benefits*. The only exception is except where clinically appropriate standards of care may permit a difference.

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

### A. Mental Health Services

This *agreement* covers *medically necessary* services for the treatment of mental health disorders in a *general* or *specialty hospital* or *outpatient* facilities that are:
- reviewed and approved by us; and
- licensed under the laws of the State of Rhode Island or by the state in which the facility is located as a *general* or *specialty hospital* or *outpatient* facility.

We review *network* and *non-network* programs, *hospitals* and *inpatient* facilities, and the specific services provided to decide whether a *preauthorization*, *hospital* or *inpatient* facility, or specific services rendered meets our *program* requirements, content and criteria. If our *program* content and criteria are not met, the services are not covered under this *agreement*. Our *program* content and criteria are defined below.

#### Inpatient

If you are an *inpatient* in a *general* or *specialty hospital* for mental health services, this *agreement* covers *medically necessary hospital services* and the services of an attending physician for the number of *hospital* days shown in the Summary of Benefits. See Section 3.20 – Inpatient Hospital Services for additional information. *Preauthorization* is recommended for *inpatient* mental health services.

#### Intermediate Care Services

Intermediate Care Services are facility based *programs* used as a step down from a higher level of care or a step-up from standard care. See the Summary of Benefits for level of coverage. *Preauthorization* is recommended for intermediate care services.
This *agreement* covers the following mental health Intermediate Care Services:

- **Partial Hospital Program (PHP)** – This *agreement* covers 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 and must consist of, but not limited to, group, individual, and family therapy, medication evaluation and management services. PHP must be supervised by a licensed independent clinician who is responsible for the *program* and staff. Licensed independent clinicians include MD’s, DO’s, RN’s with an advanced training and prescriptive privileges (for example, a Clinical Nurse Specialist), PhD’s, LICSW’s, LMHC’s, LMFT’s, or individuals with equivalent independent practicing licenses in the state the *program* operates. PHP 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)** – This *agreement* covers 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 and must consist of, but not limited to, individual, group, and family therapy, medication evaluation and management services. IOP must be supervised by a licensed independent clinician who is responsible for the *program* and staff. Licensed independent clinicians include MD’s, DO’s, RN’s with an advanced training and prescriptive privileges (for example, a Clinical Nurse Specialist), PhD’s, LICSW’s, LMHC’s, LMFT’s, or individuals with equivalent independent practicing licenses in the state the *program* operates. IOP 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)** – This *agreement* covers 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, ongoing *emergency/crisis* evaluations that are available 24 hours a day 7 days per week, psychiatric assessment, medication evaluation and management, case management, psychiatric nursing services, and individual, group, and family therapy. The *program* requires the health care *provider* to render a minimum of six (6) contact hours per week.

- **Child and Family Intensive Treatment (CFIT)** – This *agreement* covers child and family intensive treatment services that are approved by us and meet our criteria for participation. CFIT is a facility based mental health care *program*. The *program* is primarily based in the home for qualifying children with moderate to severe psychiatric conditions. CFIT services must consist of, but are not limited to individual, family, and group counseling; medication consultation and management; and case management coordination with a school, state agency, *outpatient providers*, and/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 until their nineteenth (19th) birthday.
In a Provider’s Office/In your Home
This agreement covers the following mental health specialists:
• Board certified 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 and must meet our credentialing criteria.

Covered mental health services include medically necessary individual psychotherapy, group psychotherapy, and family therapy when rendered by a mental health specialist, as listed above. See the Summary of Benefits for the level of coverage.

This agreement covers medication visits when rendered by a psychiatrist or a clinical nurse specialist in behavioral health. See the Summary of Benefits for benefit limits and level of coverage. See Section 3.23 - Office Visits.

Electroconvulsive Therapy
This agreement will cover electroconvulsive therapy (ECT) services when performed and billed by a psychiatrist. This agreement covers anesthesia services when rendered by an anesthesiologist. See Section 3.34 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 (e.g., Alcoholics Anonymous (AA), Narcotics Anonymous (NA) meetings/services);
• mental health residential treatment programs (including eating disorder residential treatment programs);
• mental health services performed in a residential treatment facility
• mental health services performed in a hospital, or any inpatient facility, when the hospital or inpatient facility is used for residential treatment purposes;
• 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;
• Behavioral training assessment, education or exercises, including applied behavioral analysis; and
• Computer based, internet, and social media services and/or programs.

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 Facilities We Have Not Approved and Section 4.8 for People/Facilities Who Are Not Legally Qualified or Licensed.

For benefit information regarding coverage of substance abuse in a hospital, substance abuse treatment facility, or an acute substance abuse rehabilitation/residential facility see Section B. Substance Abuse Treatment, below.

B. Substance Abuse Treatment
This agreement covers medically necessary services for the treatment of substance abuse in a hospital, substance abuse treatment facility, or an acute substance abuse rehabilitation/residential facility that is:

• reviewed and approved by us; and
• licensed under the laws of the State of Rhode Island or by the state in which the facility is located as a hospital, a substance abuse treatment facility, or an acute substance abuse residential/rehabilitative facility.

We review network and non-network programs, hospital or inpatient facilities, acute substance abuse rehabilitation/residential facilities and the specific services provided. We decide whether a program, hospital or inpatient facility, acute substance abuse rehabilitation/residential facility, or specific services rendered meets our program requirements, content and criteria. If our program requirements, content and criteria are not met, the services are not covered under this agreement. Our program content and criteria are defined below.

Inpatient Hospital
If you are an acute inpatient in a general or specialty hospital for behavioral health services, we cover medically necessary acute hospital services for detoxification. See Section 3.20 - Inpatient Hospital Services for additional information. Preauthorization is recommended.
Substance Abuse Treatment Facility
This agreement covers medically necessary services at an Acute Rehabilitation or Acute Substance Abuse Residential facility when reviewed by us and we decide that, at a minimum, the following program criterion has been met:

- Certified clinical staff available twenty-four (24) hours per day, seven (7) days a week to meet the member's medical and psychological needs.
  - includes a registered nurse (RN) available on site a minimum of eight (8) hours day and on call twenty-four (24) hours a day;
  - when on call, the RN must be able to be on site within one (1) hour of a call.
- Program must be supervised by a licensed independent clinician that is in charge of the program and the staff;
  - Licensed independent clinicians are defined as the following:
    - M.D., D.O., or R.N. with advanced training and prescriptive privileges (i.e. Clinical Nurse Specialist),
    - Ph.D. LICSW, LMHC, LMFT, or an individual with an equivalent independent practicing license in the state in which the program operates.
- Program must have a licensed physicians on staff who is available twenty-four (24) hours per day, seven (7) days per week to evaluate patients and adjust medication as needed and provide medical oversight of all patients in the program.
- Program structure must include evidenced-based treatment at a minimum of six (6) hours of clinical programming per day Monday through Friday, and four (4) hours per day on weekends.

Recreational, educational and other complementary activities, including, but not limited to, Tai Chi, yoga, personal training, meditation time, exercise, etc., do not count towards the above noted clinical hourly program requirements as they are non-covered, non-clinical services.

Recreation therapy, non-medical self-care, or self-help training (e.g., Alcoholics Anonymous (AA), Narcotics Anonymous (NA) meetings/services, etc.) are non-covered services and do not count toward the above noted clinical hourly program requirements. (Please see the Related Exclusion section below for more information.)

Substance Abuse Treatment Facility/Intermediate Care Services
This agreement covers services for the treatment of substance abuse for individuals and family members covered under this agreement when rendered at a substance abuse treatment facility or a state-licensed provider/program that we have approved.

Intermediate Care Services are facility based programs used as a step down from a higher level of care or a step-up from standard outpatient care. See the Summary of Benefits for the level of coverage. Preauthorization is recommended for intermediate care services.
This *agreement* covers the following *substance abuse* Intermediate Care Services:

- **Partial Hospital Program (PHP)** – This *agreement* covers 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 and must consist of, but not limited to, group, 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 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)** – This *agreement* covers 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 and must consist of, but not limited to, individual, group, and family therapy, medication evaluation and management services, and must be available 24-hours a day 7 days per week for support of the patient. This *program* must provide substantial clinical support for patients who are either in transition from the *hospital* to an *outpatient* setting or at risk for admission to *inpatient* care or other higher levels of care.

- **Adult Intensive Service (AIS)** – This *agreement* covers 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 *substance abuse* conditions. This *program* must consist of, but is not limited to, ongoing *emergency/crisis* evaluations that are available 24 hours a day 7 days per week, psychiatric and addiction assessment, medication evaluation and management, case management, addiction nursing services, and individual, group, and family therapy. The *program* requires the health care *provider* to render a minimum of six (6) contact hours per week.

- **Child and Family Intensive Treatment (CFIT)** – This *agreement* covers child and family intensive treatment services that are approved by us and meet our criteria for participation. CFIT is a facility based *substance abuse* health care *program*. The *program* is primarily based in the home for qualifying children with moderate to severe *substance abuse* conditions. CFIT services must consist of, but are not limited to individual, family, and group counseling; medication consultation and management; and case management coordination with a school, state agency, *outpatient providers*, and/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 until their nineteenth (19th) birthday.

**In a Provider’s Office/In your Home**

This *agreement* covers services for the treatment of *substance abuse* for individuals and family *members* covered under this *agreement*. The services may be rendered in a *provider’s office* or in your home.
This *agreement* covers the following behavioral health specialists:

- Psychiatrists;
- Licensed independent 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 to be considered for benefit coverage.

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

**Related Exclusions**
This *agreement* does NOT cover the following *substance abuse* treatment services:

- Recreation therapy, non-medical self-care, or self-help training (e.g., e.g., Alcoholics Anonymous (AA), Narcotics Anonymous (NA) meetings/services);
- Telephone consultations (See Section 4.16);
- Therapeutic recreation programs, extended stay/long term residential or wilderness programs;
- Services provided in any covered program that are reviewed by us and we decide are recreation therapy programs, wilderness programs, educational programs, complimentary programs, or non-clinical services (examples of services that are not covered include, but is not limited to, Tai Chi, yoga, personal training, meditation, and internet based support/education);
- Computer based/internet/social media services and/or programs.

This *agreement* does NOT cover *substance abuse* treatment when:

- the *provider* does NOT meet our eligibility and/or credentialing requirements;
- the *program* is not approved by us for benefit coverage; or
- treatment is rendered at facilities that are not approved and/or licensed by the state in which the facility is located. See Section 4.6 for Facilities We Have Not Approved and Section 4.8 for People/Facilities Who Are Not Legally Qualified or Licensed.
This *agreement* does NOT cover methadone clinics and treatments. See Section 4.6 - Facilities We Have Not Approved and Section 4.8 - People/Facilities Who Are Not Legally Qualified or Licensed.

### 3.3 Cardiac Rehabilitation

**Outpatient**

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

### 3.4 Chiropractic Medicine

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

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

**Related Exclusions**

This *agreement* does NOT cover:

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

### 3.5 Dental Care

**Emergency Dental Services**

**In a Hospital Emergency Room**

Accident includes an accidental injury to your *sound natural teeth*. Accidental injuries are those caused by unexpected and unintentional means. We cover the hospital or emergency room services and the doctor’s or dentist’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).

**In an Office**

If you receive the *dentally necessary* services due to an accidental injury to your *sound natural teeth* in a doctor/dentist’s office, you are responsible for any applicable office visit *copayment*. See the Summary of Medical Benefits for details.
Dentally necessary services are covered when received within seventy-two (72) hours of an accidental injury to your sound natural teeth. The following services are covered:

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

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

**Hospital and Anesthesia Services Provided in Connection with a Dental Service**
Hospital services and free-standing ambulatory surgi-center services provided in connection with a dental service are covered when:

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

Preauthorization is recommended for this service.

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

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

Preauthorization is recommended for this service.
3.6 Diabetic Equipment and Supplies

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

- therapeutic/molded shoes for the prevention of amputation are covered for the treatment of diabetes; our allowance for molded shoes includes the initial inserts. Additional medically necessary inserts for custom-molded shoes are covered; and
- blood glucose monitors, blood glucose monitors for the legally blind, external insulin infusion pumps and appurtenances thereto, insulin infusion devices and injection aids for the treatment of insulin treated diabetes, non-insulin treated diabetes and gestational diabetes; and
- 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 3.27 - 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 3.23 - Office Visits. For vision care, see Section 3.37 – Vision Care Services.

3.7 Dialysis Services

Inpatient

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

Outpatient

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

Related Exclusions
If you receive dialysis services in your home, this agreement does NOT cover:
• installing or modifying of electric power, water and sanitary disposal or charges for these services;
• moving expenses for relocating the machine;
• installation expenses not necessary to operate the machine; or
• training you or members of your family in the operation of the machine.

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

3.8 Durable Medical Equipment, Medical Supplies, Enteral Formula or Food, & Prosthetic Devices
We cover medically necessary durable medical equipment, medical supplies, and prosthetic devices that meet the minimum specifications.

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

DURABLE MEDICAL EQUIPMENT is equipment (and supplies necessary for the effective use of equipment) which:
• can withstand repeated use;
• is primarily and customarily used to serve a medical purpose;
• is not useful to a person in the absence of an illness or injury; and
• is for use in the home.

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

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

Inpatient
Inpatient medically necessary durable medical equipment, medical supplies, 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 for Medical Equipment, Medical Supplies, and Prosthetic Devices - Outpatient will apply, as shown in the Summary of Medical Benefits.

**Outpatient/In Your Home**
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 rental and purchased 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 (replacement of covered durable medical equipment 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).

**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; 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 3.34 - 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 replacement of durable medical equipment and prosthetic devices prescribed because of a desire for new equipment or new technology. This agreement covers the basic item necessary to meet the typical functional need of the average person. “Deluxe” or “enhanced” equipment is not covered.

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 4.29 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 amount that you pay differs depending on whether the enteral formula or food is the sole source of nutrition delivered through a feeding tube or taken orally.

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

In accordance with Rhode Island General Law §27-20-56, this agreement covers medically necessary enteral formula taken orally for the treatment of malabsorption caused by Crohn’s disease, ulcerative colitis, gastroesophageal reflux, chronic intestinal pseudo obstruction, and inherited diseases of amino acids and organic acids. Enteral formula is covered when a doctor has issued a written order and must be for home use. Also, food products modified to be low protein are covered for the treatment of inherited diseases of amino acids and organic acids. Preauthorization is recommended.

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

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

### 3.9 Education

**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 3.23 - Office Visits. For medical equipment and supplies, see Section 3.8 - Durable Medical Equipment, Medical Supplies, Enteral Formula or Food, and Prosthetic Devices. See the Summary of Medical Benefits for *benefit limits* and the amount that you pay. For prescription drugs, see the Pharmacy Benefits Section 3.27 and the Summary of Pharmacy Benefits.

### 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 thirty-six (36) months. The children must have been certified by the Rhode Island Department of Human Services to enroll in an approved Early Intervention Services *program*. Services must be provided by a licensed Early Intervention *provider* and rendered to a Rhode Island resident. We cover Early Intervention Services as defined by the Rhode Island Department of Human Services including, but not limited to, the following:

- speech and language therapy;
- physical and occupational therapy;
- evaluation;
- case management;
- nutrition;
- service plan development and review;
- nursing services; and
- assistive technology services and devices.
See the Summary of Medical Benefits for the *maximum benefit limit* and the amount that you pay.

**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 Experimental/Investigational Services
This *agreement* only provides coverage for certain *experimental/investigational* services as required by:
- Rhode Island General Laws Sections § 27-20-60 entitled “Coverage for individuals participating in approved clinical trials”, and
- Rhode Island General Laws Title 27, Chapter 55, entitled “Off Label Use of Prescription Drugs”.  

In accordance with Rhode Island General Law §27-20-60, this *agreement* provides coverage for *members* participating in approved clinical trials.

You are qualified to participate in a clinical trial if:
- you are eligible, according to the trial protocol, and
- a *network provider* has concluded that your participation would be appropriate; or
- you provide medical and scientific information establishing that your participation in such trial would be appropriate.

RIGL § 27-20-60 describes what an approved clinical trial is. In summary, it means a phase I, phase II, phase III, or phase IV clinical trial that is being done to prevent, detect or treat cancer or a life-threatening disease or condition (a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted).

To qualify to be a clinical trial it must:
- be federally funded, or
- be conducted under an investigational new drug application reviewed by the Food and Drug Administration, or
- be a drug trial that is exempt from having such an investigational new drug application.

If a *network provider* is participating in a clinical trial, and the trial is being conducted in the State in which you reside, then you may be required to participate in the trial through the *network provider*. 
Coverage under this agreement includes routine patient costs for covered health care services furnished in connection with participation in the trial. These include covered health care services that are typically covered for a patient who is not enrolled in a clinical trial.

The amount you pay for is based on the type of service. For information about office visits, see Section 3.23 - Office Visits. For surgical procedures see Section 3.34 - Surgery Services. For lab, radiology, and machine tests see Section 3.35 - Tests, Imaging, and Labs. See the Summary of Medical Benefits for benefit limits. For prescription drugs, see Section 3.27.

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

RIGL § 27-55 explains how coverage under this agreement is available for off label prescription drugs for cancer if the prescription drug is recognized as a treatment for cancer in accepted medical literature.

**Related Exclusions**
This agreement does NOT cover any treatments, procedures, facilities, equipment, drugs, devices, supplies, or services that are experimental or investigative except as described above.

Treatments, procedures, facilities, equipment, drugs, devices, supplies, or services will be recognized as having been proven effective in clinical medicine only if one of the following apply:
- Final approval for the use of a specific service for a specific condition from the appropriate governmental regulatory body; OR
- Demonstrated, reliable evidence based upon an entry in at least one of the three standard reference compendia (shown in this Section 3.11); OR
- Sound scientific studies published in authoritative, peer reviewed medical journals that:
  - show statistically significant outcomes about the effectiveness of the service, and
  - permit a consensus of opinion that the service improves the member’s net health outcome, and
  - show it is as beneficial as any established alternatives, and
  - show that the improvement is attainable outside the investigational setting; OR
- The determination by an expert medical consultant retained by us, for the purpose of reviewing a particular service, that the service is not experimental/investigational for that particular member’s case.
A service is considered *experimental/investigational*, and therefore excluded, if one or more of the following circumstances are true:

- The service is the subject of ongoing Phase I or Phase II clinical trial or is the *experimental* arm of Phase III clinical trial, except as described above;
- Is under study to determine the maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or-
- The prevailing opinion among experts about the service is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- The current belief in the pertinent specialty of the medical profession in the United States is that the service or supply should not be used for the diagnosis or indications being requested outside of clinical trials or other research settings because it requires further evaluation for that diagnosis or indications. We will determine the applicability of this criterion based on:
  - Published reports in authoritative, peer-reviewed medical literature; AND
  - Reports, publications, evaluations, and other sources published by government agencies, such as the National Institutes of Health, the FDA, and the Agency for Healthcare Research and Quality; or
- If the benefit in question is a drug, a device, or other supply that is subject to approval by the FDA, and at least one of the following criteria apply:
  - it has not received FDA approval; or
  - it has limited FDA approval under regulations such as Treatment Investigational New Drugs; or
  - it has FDA approval but the indication for the drug or device, or the dosage, is not an accepted off-label use. We will judge this criterion through review of reports published in authoritative peer-reviewed United States medical literature OR entries in one or more of the following drug compendia:
    - The AMA Drug Evaluations;
    - The American Hospital Formulary Service Drug Information;
    - The U.S. Pharmacopoeia Dispensing Information; or
- The Institutional Review Board (IRB) of the *provider* of the service or supply acknowledges that use of it is *experimental/investigational* and is subject to the approval of the IRB; or
- The *provider* IRB requires the patient (or parent or guardian) to give an informed consent for the service or supply that states the service or supply is *experimental/investigational*, or federal law requires such a consent; or
- The research protocols related to the requested service or supply state or show the service or supply is *experimental/investigational*.

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

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

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

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

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

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

3.13 Hemophilia Services

**Outpatient/In a Doctor’s Office**
We cover the following *medically necessary* services for treatment of hemophilia:
- yearly evaluation;
- office visits;
- hemophilia *outpatient* physical therapy; and
- supplies.

For information about coverage for prescription drugs, including but not limited to clotting factor drugs, see the Section 3.27, the Pharmacy Benefit section and the Summary of Pharmacy Benefits.

3.14 Home Health Care

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

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

For information about doctor home and office visits see Section 3.23 - Office Visits. For home care equipment and supplies, see Section 3.8 - Durable Medical Equipment, Medical Supplies, Enteral Formula or Food, and Prosthetic Devices. For radiation therapy or chemotherapy services, see Section 3.30 - Radiation Therapy/Chemotherapy Services. For prescription drugs, see the Pharmacy Benefits Section 3.27 and the Summary of Pharmacy Benefits.

**Related Exclusions**
This agreement does NOT cover:

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

### 3.15 Hospice Care

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

**Related Exclusions**
This agreement does NOT cover custodial care, respite care, day care, or care in a facility that is not approved by us. See Section 4.6. Facilities We Have Not Approved.

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

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

For information about doctor home and office visits, see Section 3.23 - Office Visits. For hospice care equipment and supplies, see Section 3.8 - Durable Medical Equipment, Medical Supplies, Enteral Formula or Food, and Prosthetic Devices.

For prescription drugs, see the Pharmacy Benefits Section 3.27 and the Summary of Pharmacy Benefits.

3.16 Hospital Emergency Room Services

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

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

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

When physician services are rendered in the emergency room, other than the emergency room physician examination, the amount that you pay is based on the type of service being rendered. For surgery services (including but not limited to sutures, fracture care, and other surgical procedures), see Section 3.34 - Surgery Services. For a specialist exam, see Section 3.23 - Office Visits. For diagnostic imaging, lab and machine tests see Section 3.35. See the Summary of Medical Benefits for benefit limits and the amount that you pay for each type of service.

If you are admitted to a non-network hospital from the emergency room to receive inpatient services call our Customer Service Department at (401) 459-5000 or 1-800-639-2227 with any questions you have about your coverage.

Suture removal, performed where the original emergency 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

3.17 Human Leukocyte Antigen Testing
In accordance with Rhode Island General Law §27-20-36, we cover human leukocyte antigen testing for A, B, and DR antigens once per member per lifetime for utilization in bone marrow transplantation. The testing must be performed in a facility which is:
  • accredited by the American Association of Blood Banks or its successors; and
  • licensed under the Clinical Laboratory Improvement Act as it may be amended from time to time.

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

3.18 Infertility Services
Inpatient/Outpatient/In a Doctor's Office
In accordance with Rhode Island General Law §27-20-20, this agreement provides coverage for medically necessary services for the diagnosis and treatment of infertility. 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 are covered up to the benefit limit as shown in the Summary of Medical Benefits. Infertility prescription drug coverage is based on the route of administration and site of service. For information about prescription drugs, see Section 3.27 Pharmacy Benefits and the Summary of Pharmacy Benefits.

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

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

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

**In a Doctor's Office**
If you receive infusion therapy services in a doctor's office, we cover the related supplies and solutions. For prescription drug coverage, see Section 3.27 - Pharmacy Benefits and the Summary of Pharmacy Benefits.

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

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

For information about doctor home and office visits see Section 3.23 - Office Visits. For home care equipment and supplies, see Section 3.8 - Durable Medical Equipment, Medical Supplies, Enteral Formula or Food, and Prosthetic Devices. For radiation therapy or chemotherapy services, see Section 3.30 - Radiation Therapy/Chemotherapy Services. For prescription drugs, see the Summary of Pharmacy Benefits.

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

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### 3.20 Inpatient Hospital Services

**Inpatient**

**Semi-Private Room Charges/Days of Hospital Coverage**
We cover hospital hospital services in a ward or semi-private room in a general hospital for medical or surgical services.

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

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

**Related Exclusions**
This *agreement* does NOT cover:
- extra *charges* for a private room;
- the dental services that are performed with covered *hospital services* or with covered *free-standing ambulatory surgery center* services (see Section 4.16 for a list of excluded dental services).

### 3.21 Inpatient Doctors' Hospital Visits

For coverage of surgeons, see Section 3.34 - Surgery Services.

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

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

If, while you are in the *hospital*, the attending *doctor* in charge of your care asks for the assistance of a *doctor* who has special skills and knowledge to diagnose your condition, we cover a consultation performed by a specialist. The transferring of a patient from one *doctor* to another is not considered to be a consultation. A specialized *doctor* who then treats you as his or her patient is not considered to be a consultant.

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

### 3.22 Inpatient Rehabilitation Facility

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

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

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

**Related Exclusions**

This *agreement* does NOT cover:
- extra charges for a private room.

**3.23 Office Visits**

We cover medically necessary office visits provided they are reasonable in number and in the scope of the services rendered for the following:
- office visits to personal care physicians;
- 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 the amount that you pay. For prescription drug coverage, see Section 3.27 and Pharmacy Benefits.

Your office visit copayment to your personal care physician differs depending on whether your personal care physician practices with a patient centered medical home (PCMH) care model that is recognized by us.

**Hospital Based Clinic Visits**

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

**House Calls**

We cover doctor visits in your home if you have a condition due to an injury or illness which:
- confines you to your home;
- requires special transportation; or
- requires the help of another person.

**In a Doctor's Office**

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

When physician services are rendered in a doctor's office, other than an office visit examination, the amount that you pay is based on the type of service being rendered. For surgical services (including but not limited to sutures, fracture care, and other surgical procedures) see Section 3.43 - Surgery Services. For diagnostic imaging, lab and machine tests see Section 3.35.
Obstetrical or Gynecological Care
You do not need preauthorization from us or from any other person (including a personal care physician) in order to obtain access to obstetrical or gynecological care from a network doctor who specializes in obstetrics or gynecology. Your doctor, however, may be required to comply with certain procedures, including obtaining preauthorization for certain services. For a list of network physicians who specialize in obstetrics or gynecology, contact our Customer Service Department.

When physician services are rendered in a doctor’s office, other than an office visit examination, the amount that you pay is based on the type of service being rendered. For surgical services (including but not limited to sutures, fracture care, and other surgical procedures) see Section 3.34 Surgery Services. For diagnostic imaging, lab, and machine tests see Section 3.35.

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

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

This agreement does NOT cover the treatment of flat feet unless the treatment is surgical. Corrective or orthopedic shoes and orthotic devices used in connection with footwear are NOT covered unless for the treatment of diabetes.

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

Allogenic bone marrow transplant covered health care services include medical and surgical services for the matching participant donor and the recipient. However, Human Leukocyte Antigen testing is covered as indicated in the Summary of Medical Benefits, subject to certain conditions. For details see Section 3.17 - Human Leukocyte Antigen Testing.

Medically necessary high dose chemotherapy and radiation services related to autologous bone marrow transplantation is limited. See definition of Experimental/Investigational – Section 3.11.
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 3.11 for the definition of experimental/investigational services.

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

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

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

The amount you pay for transplant services for the recipient and eligible donor is based on the type of service. For information about office visits see Section 3.23 - Office Visits. For surgical procedures see Section 3.34 - Surgery Services. For lab, radiology, and machine tests see Section 3.35 - Tests, Imaging, and Labs. See the Summary of Medical Benefits for benefit limits. For prescription drugs, see Section 3.27 and Pharmacy Benefits.

Related Exclusions
This agreement does NOT cover:

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

3.25 Physical/Occupational Therapy
Physical and occupational therapy is covered only when:

• a program is implemented to restore or attain a higher level of independent functioning or new skills 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 skill status given your condition; and
• such improvement will not diminish with the removal of the therapeutic agent or environment.

Preauthorization is recommended for the eleventh and subsequent visit.

Inpatient

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

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

We cover medically necessary physical and occupational therapy services.

In Your Home

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

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 Medical Benefits for benefit limits and level of coverage.

Related Exclusions

This agreement does NOT cover:
• services rendered by a massage therapist,
• hippotherapy,
• maintenance services unless it is a habilitative service that helps a person keep, learn or improve skills and functioning for daily living.
• educational classes.

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

If you are covered as an individual under this agreement you must notify us and pay the appropriate family membership fee within thirty-one (31) days of delivery so that the newborn child will be covered beyond such thirty-one (31) day period. This agreement does not cover services for a newborn child who remains hospitalized after thirty-one (31) days and has not been added to a family membership. See Section 2.2 - When You Can Enroll and Make Changes - Special Enrollment.

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

Under federal law, group health plans and health insurance issuers offering group 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 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 hospital in connection with childbirth.

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

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

See Section 3.23 - Office Visits for coverage of home and office visits.
We cover hospital services provided to you and your newborn child. Your newborn child is covered for services required to treat injury or sickness. This includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities as well as routine well-baby care.

**Related Exclusions**

This agreement does NOT cover 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 3.23 - Office Visits.

**3.27 Prescription Drugs and Diabetic Equipment/Supplies**

**Definitions**

The following definitions apply to this section. Definitions that are not specific to these sections (such as copayment and deductible) are found in Section 8.0 – Glossary.

**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 pharmacy.

Quantity limits may apply to certain prescription drugs:
certain prescription drugs are subject to additional quantity limits based on criteria that we have developed, subject to our periodic review and modification. Quantity limits may restrict the amount of pills dispensed per 30 day period, the number of prescriptions orders or refills in a specified time period, or the number of prescriptions orders or refills ordered by a provider or multiple providers.

You may obtain a current list of prescription drugs that have been assigned maximum quantity levels for dispensing by visiting our Web site at BCBSRI.com or calling our Customer Service Department at (401) 459-5000 or 1-800-639-2227.

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

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

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

**PHARMACY ALLOWANCE** means the lower of:

- the amount the pharmacy charges for the prescription drug;
- the amount we or our PBM have negotiated with a network pharmacy; or
- the maximum amount we pay any pharmacy for that prescription drug.

**PRESCRIPTION DRUG 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 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 agreement, 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 BCBSRI.com or you may call our Customer Service Department at (401) 459-5000 or 1-800-639-2227.

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

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

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

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

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

Generic, preferred brand name, and non-preferred brand name prescription drugs may be dispensed at a retail pharmacy, a specialty pharmacy, a mail order pharmacy, or by a provider other than a pharmacy. Specialty prescription drugs must be dispensed at a specialty pharmacy or a non-network pharmacy. If a professional provider dispenses a specialty prescription drug, it is not separately reimbursed unless obtained from a specialty pharmacy. The administration of the specialty prescription drug is covered.

For information about the administration of specialty prescription drugs, see Section 3.2 -Behavioral Health, Section 3.13 - Hemophilia Services, Section 3.14- Home Health Care, Section 3.18 -Infertility Services, Section 3.19- Infusion Therapy, Section 3.23- Office Visits, and Section 3.30 – Radiation Therapy/Chemotherapy Services.

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

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

Coverage for prescription drugs is subject to the pharmacy program. The pharmacy program’s formulary includes a five-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.

Five-Tier Copayment Structure
This prescription drug plan formulary has a five-tier copayment structure.
First Tier: generally includes *formulary* low cost preferred generic prescription drugs, which require the lowest *copayment*.

Second Tier: generally includes other certain *formulary* low cost preferred generic prescription drugs, which require a higher copayment than the First Tier.

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

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

Fifth 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*. To obtain a copy of the most current *formulary* listing, visit our Web site at BCBSRI.com. or you may call our Customer Service Department at (401) 459-5000 or 1-800-639-2227.

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

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

**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 specialty 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 specialty prescription drugs. To obtain prescription drug preauthorization, the prescribing provider must submit a completed prescription drug preauthorization request form.

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

- By fax, submit the form to Catamaran at 1-866-391-7222;
- By phone, contact Catamaran at 1-866-391-1164;
- By mail, send the completed form to:

  Catamaran
  Prior Authorization
  P. O. Box 5252
  Lisle, IL 60532-5252

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 call 1-866-391-1164 or fax the completed form to 1-866-391-7222 and indicate the urgent nature of the request. If an expedited preauthorization review is received by us, we will respond to you with a determination within seventy two (72) hours or in less than seventy two (72) hours (taking into consideration medical exigencies) 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. If our clinical guidelines are not met for the prescription drug, you will be responsible for the cost of the prescription drug. 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.

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

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

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

If your prescribing provider deems it medically necessary that you continue to take multiple daily doses of a lower strength generic, preferred brand name, or non-preferred brand name prescription drug, prescription drug preauthorization is required and must be obtained before we provide coverage. To request prescription drug preauthorization, the prescribing provider must complete and submit a dose optimization authorization form. Coverage for multiple daily doses of a lower strength generic, preferred brand name, or non-preferred brand name prescription drug will only be approved when the dose optimization guidelines are met.
The prescribing provider may obtain a form by visiting our Web site at BCBSRI.com or calling the Physician and Provider Service Center. Requests may be submitted in one of the following ways:

- By fax, submit the form to Catamaran at 1-866-391-7222;
- By phone, contact Catamaran at 1-866-391-1164;
- By mail, send the completed form to:
  Catamaran
  Prior Authorization
  P. O. Box 5252
  Lisle, IL 60532-5252

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 call 1-866-391-1164 or fax the completed form to 1-866-391-7222 and indicate the urgent nature of the request. If an expedited dose optimization review is received by us, we will respond to you with a determination within seventy two (72) hours or in less than seventy two (72) hours (taking into consideration medical exigencies) following receipt of the request.

If you have not obtained prescription drug preauthorization by submitting a dose optimization authorization form 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. If our clinical guidelines are not met for the prescription drug, you will be responsible for the cost of the prescription drug. 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.

**Formulary Exception Process**

We have a formulary exception process that allows you to request coverage for a prescription drug that is not in our formulary. This process is available when (i) the requested prescription drug is NOT a generic equivalent of a formulary drug and your doctor determines that a formulary drug is not effective for you; or (ii) the requested non-formulary prescription drug has a generic equivalent and you have a clinical reason why you are unable to take the generic prescription drug (such as, you have had an adverse reaction to the generic medication). The process for obtaining an exception is described below.
For a *formulary* exception where the requested prescription drug is NOT a generic equivalent of a *formulary* drug the prescribing *provider* may obtain a Medical Exception Form by visiting our web site at BCBSRI.com or calling the Physician and Provider Service Center. Requests may be submitted in one of the following ways:

- By fax, submit the form to Catamaran at 1-866-391-7222;
- By phone, contact Catamaran at 1-866-391-1164;
- By mail, send the completed form to:
  
  Catamaran  
  Prior Authorization  
  P. O. Box 5252  
  Lisle, IL 60532-5252

For a *formulary* exception where the requested prescription drug has a generic equivalent, you or your prescribing provider submits a Formulary Exception Request form to our Grievance and Appeal Unit. The form will request medical information describing the clinical reason why you are unable to be treated with the generic medication. This form may be obtained from the Grievance and Appeals Unit. The GAU may be reached by phone at 401-459-5784.

The completed Formulary Exception Request form is mailed to:

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

For both types of formulary exceptions noted above, a written determination will be sent to you and to your doctor.

If we deny your request for a formulary exception, that denial is an *adverse benefit determination*. Please see Section 7.1 – Adverse Benefit Determinations for information on how to appeal our decision.

**Restricted Pharmacy**

We may limit your selection of a pharmacy to one (1) *network pharmacy*. Those *members* subject to this restriction include, but are not limited to, *members* that have a history of:

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

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.bcbsri.com.

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;
• prescription drugs purchased from a non-designated pharmacy, if a pharmacy has been designated for you through the restricted pharmacy program;
• experimental prescription drugs (including those placed on notice of opportunity hearing status by the Federal Drug Efficacy Study Implementation (DESI);
• drugs you take or have given to you while you are a patient in a hospital, rest home, sanitarium, nursing home, home care program, or other institution that provides prescription drugs as part of its services or which operates its own facility for dispensing prescription drugs;
• non-medical substances (regardless of the reason prescribed, the intended use, or medical necessity);
• off-label use of prescription drugs (except as described in Section 3.11 Experimental/Investigational Services);
• over-the-counter (OTC) drugs even if prescribed, unless specifically listed as a covered health care service in this agreement (e.g., such as OTC nicotine replacement therapy in accordance with Rhode Island General Law 27-20-53 and PPACA;
• 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.

This agreement 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:
• long acting opioids and other controlled substances;
• nicotine replacement therapy; and
• specialty prescription drugs.

Certain specialty prescription drugs are only covered if:
• prescription drug preauthorization is obtained; and
• you agree to participate in health management programs.

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

Multiple daily doses of a generic, preferred brand name, or non-preferred brand name prescription drug are NOT covered when dose optimization conditions are not met.
Certain prescribed prescription drugs that have an over-the-counter equivalent (OTC) are NOT covered under this agreement. To obtain the list of OTC prescription drugs visit our Web site at BCBSRI.com or contact our Customer Service Department at (401) 459-5000 or 1-800-639-2227.

B. Generic, Preferred Brand Name, or Non-Preferred Brand Name Prescription Drugs Dispensed and Administered by a Licensed Health Care Provider (other than a Pharmacy)
Generic, preferred brand name, or non-preferred brand name prescription drugs we have approved that are dispensed and administered by a licensed health care provider (other than a pharmacy) are covered under this agreement, subject to the copayment and deductible (if any) shown in the Summary of Medical Benefits. The generic, preferred brand name, or non-preferred brand name prescription drug must be dispensed per our dispensing guidelines in order to be covered.

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

Outpatient/In Your Doctor’s Office/In Your Home
Generic, preferred brand name, or non-preferred brand name prescription drugs are covered at different benefit levels depending upon the route of administration. Our allowance for services rendered by the facilities, agencies, and professional providers may include the cost of the prescription drugs administered and/or dispensed. We will determine coverage based upon the route of administration that is customary and least invasive method to treat the condition. There are several ways to administer drugs into the body including:
- inhalation (into the lungs, usually through the mouth);
- intramuscular (injected into a muscle);
- intrathecal (injected into the space around the spinal cord);
- intravenous/infused/intra-arterial (into a vein or artery);
- nasal (sprayed into the nose);
- ocular (instilled in the eye);
- oral (by mouth);
- rectal or vaginal (inserted into the rectum or vagina);
- subcutaneous (injected beneath the skin);
- sublingual (under the tongue);
- topical (applied to the skin); OR
- transdermal (delivered through the skin by a patch).
Inhalation, Nasal, Ocular, Oral, Rectal Or Vaginal, Sublingual, Topical, And Transdermal Generic, Preferred Brand Name, or Non-Preferred Brand Name Prescription Drugs
The prescription drug is included in our \textit{allowance} for the medical service being rendered. If the sole service is drug dispensing, the prescription drug is NOT covered.

\textbf{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 \textit{benefit limits} and the amount that you pay. See Section 3.28 Preventive Care Services and Early Detection Services for immunization and vaccination coverage information.

\textbf{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 \textit{benefit limits} and the amount that you pay.

\textbf{Related Exclusions}
\textit{Specialty prescription drugs} are not separately reimbursed unless bought from a specialty pharmacy.

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

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

\textbf{3.28 Preventive Care Services and Early Detection Services}
In accordance with PPACA, this \textit{agreement} provides coverage rendered to a \textit{subscriber} for early detection services, preventive \textit{care services}, and immunizations/vaccinations as set forth below and in accordance with the guidelines of the following resources:
\begin{itemize}
  \item services that have an A or B rating in the current recommendations of the U.S. Preventative Services Task Force (USPSTF);
\end{itemize}
• 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);
• preventive care and screenings for women as outlined in the comprehensive guidelines as supported by HRSA.

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

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

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

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

Smoking Cessation Programs
In accordance with Rhode Island General Law §27-20-53, this agreement provides coverage for smoking cessation programs. Smoking cessation programs include, but are not limited to, the following:
• Smoking cessation counseling, such counseling must be provided by a physician or upon his or her referral by a qualified licensed practitioner.
• Over-the-counter or FDA approved nicotine replacement therapy and/or smoking cessation prescription drugs when medically necessary, prescribed by a physician, and purchased at a pharmacy. See Summary of Pharmacy Benefits for details on coverage.

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

**Vaccinations/Immunizations**
If any of the covered 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 covered 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.

**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.

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

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

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

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

**Preventive Screening/Early Detection Services**
Preventive screening such as pap smears, mammograms, and colonoscopies are covered based on the PPACA guidelines noted above. Coverage levels are as specified in the Summary of Medical Benefits.
Genetic Counseling for BRCA
This agreement provides coverage for genetic counseling and evaluation performed by a certified genetic counselor for BRCA testing for female subscribers whose family history is associated with an increased risk for deleterious (harmful) mutations in BRCA1 or BRCA2 genes.

Contraceptive Methods and Sterilization Procedures for Women
This agreement provides coverage for FDA approved contraceptive drugs requiring a prescription, FDA approved contraceptive devices requiring a prescription, and sterilization procedures for women with reproductive capacity. See the Summary of Medical Benefits and Summary of Pharmacy Benefits for benefit limits and level of coverage.

Vasectomy (sterilization procedure for men) is covered as a surgical procedure. See Section 3.34 - Surgery Services and the Summary of Medical Benefits for details about how we cover surgical services.

Related Exclusions
This agreement does not cover contraceptive drugs, devices, and methods that do not require a prescription (OTC drugs, devices, and methods).

Breastfeeding Counseling and Equipment
This agreement provides coverage for lactation (breastfeeding) support and counseling by a trained lactation counselor during pregnancy and/or in the postpartum period. Breastfeeding counseling is included in our allowance for an outpatient clinic visit or an office visit.

This agreement provides coverage for manual (operated by hand) breast pumps for a female member in conjunction with each birth. See the Summary of Medical Benefits for benefit limits and level of coverage.

Related Exclusions
This agreement does not cover electric/battery operated breast pumps, except when there is involuntary separation of an infant from its mother for more than twenty-four (24) hours as a result of hospitalization of the infant due to illness or injury. Once the infant is discharged from the hospital, we will no longer provide coverage for an electric/battery operated breast pump.

3.29 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.);
- services of a private duty nurse that are for observation only.

### 3.30 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 3.11.

**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.

### 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

### 3.31 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 as stated in the Summary of Medical Benefits for medical equipment and medical supplies. See Section 3.8 - Durable Medical Equipment, Medical Supplies, Enteral Formula or Food, and Prosthetic Devices for details.

**Related Exclusions**

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

### 3.32 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 - Facilities We Have Not Approved.

### 3.33 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**
This *agreement* covers *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**
This *agreement* will cover speech therapy 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;
- an acute exacerbation of chronic disease, or
- the development of a new speech or communication skill, and
- such improvement will not diminish with the removal of the therapeutic agent or environment.

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 3.34 – Tests, Imaging, and Labs and the Summary of Medical Benefits for *benefit limits* and the amount that you pay.

**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 unless it is a habilitative service that helps a person keep, learn or improve skills and functioning for daily living;
• educational classes and services for impairments that are self-correcting; or
• services related to food aversion or texture disorders

3.34 Surgery Services

General Surgery
If you have an operation to treat a disease or injury, we cover it as long as the following conditions apply:
• the operation is not experimental/investigational or cosmetic in nature;
• the operation is being performed at the appropriate place of service; AND
• the doctor is licensed to perform the surgery.

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

If More Than One Surgeon Operates
In addition to the type and purpose of surgery, our allowance differs depending on the number of surgeons involved, including assistant surgeons.

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

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

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

This agreement provides benefits for mastectomy surgery and mastectomy-related services in accordance with the Women’s Health and Cancer Rights Act of 1998 and Rhode Island General Law 27-20-29 et seq. For the member receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

**Surgery to Treat Functional Deformity or Impairment**
Reconstructive surgery and procedures are covered under this agreement when performed to correct:

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

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

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

- Abdominal wall surgery including Panniculectomy (other than an abdominoplasty);
- Blepharoplasty and Ptosis Repair;
- Gastric Bypass or Gastric Banding;
- Nasal Reconstruction and Septorhinoplasty;
- Orthognathic surgery including Mandibular and Maxillary Osteotomy;
- Reduction Mammoplasty;
- Removal of Breast Implants;
- Removal or Treatment of Proliferative Vascular Lesions and Hemangiomas; or
- Treatment of Varicose Veins.
We may need to review the following medical documentation to be able to make a decision about coverage for the above listed procedures:

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

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

**Related Exclusions**

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

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

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

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

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

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

- Abdominoplasty;
- Brow ptosis surgery;
- 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;
• 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; and
• Treatment of vitiligo.

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

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

Our allowance for the surgical procedure includes local anesthesia.
Other than the pre-operative office visit, this agreement covers office visits or office consultations to anesthesiologists as an office visit. See Section 3.23 - Office Visits.

**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.

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

#### Inpatient/Outpatient/In a Doctor's Office
If a doctor orders the following tests to diagnose or treat a condition resulting from illness or injury, we cover the following services:

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

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

For the purpose of coverage under this agreement, preauthorization is recommended for the following services:
- MRI;
- MRA;
- CAT scans;
- CTA scans;
• PET scans; and
• Nuclear Cardiac Imaging.

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

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

If a diagnostic imaging, lab or machine test service is rendered and a surgical procedure is performed at the same time, the amount that you pay for each service is based on the type of service being rendered. For surgical services (including but not limited to biopsies, lesion removals, or endoscopies) see Section 3.34 Surgery Services. For diagnostic imaging, labs, or machine tests see Section 3.35 - Tests, Imaging, and Labs.

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

If a diagnostic imaging, lab or machine test service is rendered and a surgical procedure is performed at the same time, the amount that you pay for each service is based on the type of service being rendered. For surgical services (including but not limited to biopsies, lesion removals, or endoscopies) see Section 3.34 Surgery Services. For diagnostic imaging, labs, or machine tests see Section 3.35 - Tests, Imaging, and Labs.

**Related Exclusions**

This *agreement* does NOT cover the following:

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

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

For coverage of specific services, 3.24 - Office Visits, 3.20 - Infusion Therapy, and for prescription drugs, 3.28 and Pharmacy Benefits.

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

3.37 Vision Care Services
Eye Examinations
We cover one (1) routine eye exam per plan year for all members regardless of age if an optometrist or ophthalmologist performs the examination. We cover medically necessary eye examinations.

Pediatric Vision Hardware (for members up until the age of nineteen (19))
This agreement covers collection prescription glasses (lenses and/or frames) as shown in the Summary of Medical Benefits.

This agreement covers collection contact lenses as shown in the Summary of Medical Benefits. Preauthorization is recommended for additional contact lenses due to one of the following conditions:

- Anisometropia of 3D in meridian powers
- High Ametropia exceeding −10D or +10D in meridian powers
- Keratoconus when the member’s vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses
- Vision improvement for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to the best corrected standard spectacle lenses

To obtain preauthorization, the prescribing provider must submit a completed preauthorization request form.

The prescribing provider may obtain a preauthorization form by visiting our Web site at BCBSRI.com or calling the Physician and Provider Service Center. Preauthorization requests may be submitted:

- By phone, contact EyeMed Vision Care at 1-866-723-0513;
- By mail, send the completed form to:
Contact lenses for which *preauthorization* is recommended will only be approved when clinical guidelines are met. The guidelines are based upon clinically appropriate criteria that ensure that the contact lens is appropriate and cost-effective for the illness, injury or condition for which it has been prescribed.

**Related Exclusion**

This *agreement* does not cover:

- vision hardware for a *member* aged nineteen (19) and older;
- vision hardware purchased from a *non-network provider*; and
- non-collection vision hardware.
4.0 HEALTH CARE SERVICES NOT COVERED UNDER THIS AGREEMENT

This agreement does NOT cover health care services which:
• have not been assigned a CPT or other code;
• have not been finally approved by the FDA or other governing body;
• we have not reviewed; or
• we have not determined are eligible for coverage.

This agreement does not provide coverage for all health care services which:
• have been assigned a CPT code;
• have been finally approved by the FDA or other governing body; or
• we have reviewed.

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

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

4.1 Services Not Medically Necessary

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

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

We may deny payments if a doctor or hospital does not supply medical records needed to determine medical necessity. We may also deny or reduce payment if the records sent to us do not provide adequate justification for performing the service.
This *agreement* does NOT cover routine screenings or tests performed by a *hospital* which are not *medically necessary* for the diagnosis or treatment of your condition. This *agreement* does NOT cover routine screenings or tests which are not specifically ordered by the *doctor* who admits you.

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

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

### 4.4 Behavioral Training Assessment
This *agreement* does not cover behavioral training assessment, education or exercises including applied behavioral analysis.

### 4.5 College/School Health Facilities Services
This *agreement* does NOT cover dental and 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 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 Excluded Providers
This *agreement* does NOT cover dental and 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 People/Facilities Who Are Not Legally Qualified or Licensed
This agreement does NOT cover dental and health care services performed in a facility or by a dentist, 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 Naturopaths and Homeopaths
This agreement does NOT cover health care services ordered or performed by naturopaths and homeopaths.

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

4.11 Benefits Available from Other Sources
This agreement does NOT cover the cost of covered dental and 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 dental and 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
Except for those dental services listed as covered, (see Section 3.5), 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 dental and health care services when performed to treat work-related illnesses, conditions, or injuries whether or not you are covered by Workers’ Compensation law, unless;
• you are self-employed, a sole stockholder of a corporation, or a member of a partnership;
• such work-related illnesses, conditions, or injuries were incurred in the course of your self-employment, sole stockholder, or partnership activities; AND
• you are not enrolled as an employee under a group health plan sponsored by an employer other than the business or partnership described above.

However, if your employer is self-insured against Workers’ Compensation liabilities pursuant to a Rhode Island group or individual self-insurance plan for which we provide administrative claims management services, to the extent required by our contract with such plan, we process bills and payments for health care services arising out of work-related illnesses, conditions, or injuries covered by such plan as if the services were covered under this agreement. Although we provide administrative claims management services only, for the purposes of any participating contract between us and (1) a hospital or other health care facility, and (2) a laboratory or any other provider of professional services, you will be deemed to be a subscriber receiving services performed under this agreement.

4.20 Eye Exercises
Eye exercises and visual training services are NOT covered.

4.21 Eyeglasses and Contact Lenses
Eyeglasses (lenses and/or frames) and contact lenses are NOT covered for members aged nineteen and older.
4.22 Food and Food Products
This *agreement* does NOT cover nutritional supplements and 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 and Parentage Testing
This *agreement* does NOT cover gene therapy and 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
This agreement does NOT cover research studies.

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

4.32 Services Provided By Relatives or Members of Your Household
This agreement does NOT cover charges for any services provided by a person who is a member of your household or the cost of any care provided by one of your relatives (by blood, marriage, or adoption).
4.33 **Sex Transformations and Dysfunctions**
Health care services related to sex transformations are NOT covered. Health care services related to sexual dysfunctions or inadequacies, except services approved by us and necessary for the treatment of a condition arising out of organic dysfunctions, are NOT covered. (i.e., Therapeutic services will be covered when the cause of the dysfunction is physiological, not psychological.) This *agreement* does NOT cover sildenafil citrate (e.g., Viagra) or any therapeutic equivalents.

4.34 **Supervision of Maintenance Therapy**
This *agreement* does NOT cover the supervision of maintenance therapy for chronic disease which is not aggravated by surgery and would not ordinarily need hospitalization unless it is a habilitative service that helps a person keep, learn or improve skills and functioning for daily living.

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 including but not limited to, commercial diet plans, weight loss programs, and any services in connection with such plans or programs. The only exception is preventive obesity screening and counseling services required by PPACA. See Section 3.28-Preventive Care Services and Early Detection Services.
5.0 HOW YOUR COVERED HEALTH CARE SERVICES ARE PAID

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

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

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 medical claims to:
Blue Cross & Blue Shield of Rhode Island
Attention: Claims Department
500 Exchange Street
Providence, RI 02903
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 1.14 – Your Responsibility to Pay Your Providers for more information.

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

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

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

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

5.3 Coverage for Services Provided Outside of the Service Area (BlueCard)
Out-of-Area Services
BCBSRI has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever you obtain healthcare services outside of BCBSRI service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between us and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside BCBSRI service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from nonparticipating healthcare providers. BCBSRI payment practices in both instances are described below.

A. BlueCard® Program

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

Whenever you access covered healthcare services outside BCBSRI’s service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

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

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

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

Federal law or laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.
B. Non-Participating Healthcare Providers Outside BCBSRI Service Area

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

2. Exceptions
In certain situations, BCBSRI may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount BCBSRI will pay for services rendered by non-participating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment BCBSRI will make for the covered services as set forth in this paragraph.
6.0  **HOW WE COORDINATE YOUR BENEFITS WHEN YOU ARE COVERED BY MORE THAN ONE PLAN**

**Introduction**

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

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

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

**6.1 Definitions**

The following definitions apply to Section 6:

- **ALLOWABLE EXPENSE** means the necessary, reasonable and customary item of expense for health care which is:
  - covered at least in part under one or more plans covering the person for whom the claim is made; AND
  - incurred while this agreement is in force.

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

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

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

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

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

- **SECONDARY PLAN** means a plan which is not a primary plan.
6.2 **When You Have More Than One Agreement with Blue Cross & Blue Shield of Rhode Island**

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

6.3 **When You Are Covered By More Than One Insurer**

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

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

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

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

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

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.

\[
\text{Total Benefits Payable} = \text{Maximum benefits paid by first insurer} + \text{Any remaining allowable expense paid by other insurer}
\]
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 ADVERSE BENEFIT DETERMINATION AND APPEALS

7.1 Adverse Benefit Determinations

An **adverse benefit determination** is any of the following:
- Denial of a benefit (in whole or part),
- Reduction of a benefit,
- Termination of a benefit,
- Failure to provide or make a payment (in whole or in part) for a benefit,
- Denial, reduction, termination, or failure to make a payment based on the imposition of a preexisting condition exclusion, a source of injury exclusion, or other limitation on covered benefits, and
- Rescission of coverage, even if there is no adverse effect on any benefit.

An appeal of an **adverse benefit determination** can be made either as an **administrative appeal** or as a **medical appeal**, as defined further in this section.

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

7.2 Complaint and Administrative Appeal Procedures

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

An **Administrative Appeal** is a verbal or written request for us to reconsider a full or partial denial of payment for services that were denied because:
- the services were excluded from coverage;
- we failed to make payment (in whole or part) for a service;
- we determined that you were not initially eligible for coverage;
- we determined that you were not eligible for coverage (for example, a rescission of coverage occurred);
- you or you or your **provider** did not follow Blue Cross & Blue Shield of Rhode Island’s requirements; or
- other limitation on an otherwise covered benefit.
How to File a Complaint or Administrative Appeal

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

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

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

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

Please mail the complaint or administrative appeal to:

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

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

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

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

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

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

### 7.3 Medical Appeal Procedures

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

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

If we deny payment for a service for medical reasons, you will receive the denial in writing.

The written denial you receive will:

- explain the reason for the denial,
- explain the clinical criteria that was used to make the determination,
- provide specific instruction for obtaining the clinical criteria for the denial, and
- provide specific instructions for filing a medical appeal.

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

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

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

Written medical appeals should be sent to:
Blue Cross & Blue Shield of Rhode Island
Attention: Grievance and Appeals Unit
500 Exchange Street
Providence, Rhode Island 02903

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

Within ten (10) business days of receipt of a written or verbal medical appeal, the Grievance and Appeals Unit will mail or call you to phone acknowledge of our receipt of the medical appeal.

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

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 (Level 1 review) 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 the date 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 1.7 – Preauthorization for additional information about urgent *preauthorization* requests);
- the circumstances are an emergency; or
- you are in an *inpatient* setting.

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

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

An expedited appeal determination for services that have not yet been rendered (a pre-service review) will be made not later than seventy-two (72) hours or in less than seventy-two (72) hours (taking into consideration medical exigencies) 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 for any *claim* amount. There is no minimum dollar amount that a *claim* must be in order to file an external appeal.

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.

We may charge you a filing fee up to $25.00 per external appeal, not to exceed $75.00 per *plan year*. We will refund you if the denial is reversed and will waive the fee if it imposes an undue hardship on you.

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.

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

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).
For members covered by a group (employer sponsored) health plan, your plan may be subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Under federal law, if your plan is subject to ERISA you may have the right to bring legal action under section 502(a) of ERISA after you have exhausted all available administrative appeals. For appeals other than medical appeals, federal law requires that you pursue a final decision on an administrative appeal prior to filing suit under section 502(a) of ERISA. For medical appeals, federal law requires that you pursue a Level 2 review prior to filing a suit under section 502(a) of ERISA. You are not required to submit your claim to external review prior to filing a suit under section 502(a) of ERISA. Consult your employer to determine whether this applies to you and what your rights and obligations may be. If you are dissatisfied with the decision on your claim, and have complied with applicable state and federal law, you are entitled to seek judicial review. This review will take place in an appropriate court of law.

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

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

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

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

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

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

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

We can collect the money no matter where it is or how it is designated. You must pay us back even if you do not get back the total amount of your claim against the third party. We can collect the money you receive even if it is described as a payment for something other than health care expenses. We may offset future payments under this agreement until we have been paid an amount equal to what you were paid by a third party. If we must pay legal fees in order to recover money from you, we can recover these costs from you. Also, the amount that you must pay us cannot be reduced by any legal costs that you have.

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

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

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

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

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

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

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

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

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

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.

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

COBRA means the Consolidated Omnibus Budget Reconciliation Act passed by Congress in 1986. This law provides continuation of group health plan coverage that would otherwise be ended. COBRA gives certain former employees, retirees, spouses, and dependents the right to temporary continuation of health coverage at group rates.
COPAYMENT means either a defined dollar amount or a percentage of our allowance that you must pay for certain covered health care services.

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

DEDUCTIBLE means the amount that you must pay each plan year before we begin to pay for certain covered health care services. The network provider and non-network provider plan 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 plan 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 covers developmental services unless specifically listed as not 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. We or HealthSource RI may be the entity that determines eligibility for coverage under this agreement. See Section 2.1 for a detailed description of who is eligible to enroll as a dependent under this agreement.

EMERGENCY means a medical condition manifesting itself by acute symptoms. The acute symptoms are severe enough (including severe pain) that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that without immediate medical attention serious jeopardy to the health of a person (or, with respect to a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions, or serious dysfunction of any bodily organ or part could result.

EXPERIMENTAL/INVESTIGATIONAL means any health care service that has progressed to limited human application, but has not been recognized as proven and effective in clinical medicine. See Section 3.11 for a more detailed description of the type of health care services we consider experimental/investigational.
**EMPLOYER/AGENT** means any individual, corporation, association or college or university that pays for some or all of your membership and benefits as described in this *agreement*. This person or company is separate from us. Membership applications may be prepared by you and delivered to us by your *employer/agent*.

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

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

**HEALTHSOURCE RI** means a Rhode Island governmental agency that makes Qualified Health Plan (QHPs) available to qualified employees. It works as a marketplace to help residents identify health insurance options. To contact, please call 1-855-683-6759.

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

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

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

*Hospital* does not mean:
- convalescent homes;
- rest homes;
- nursing homes;
- homes for the aged;
- school and college infirmaries;
- halfway houses or residential facilities;
• long-term care facilities;
• **urgent care centers** or **free-standing ambulatory surgi-centers**;
• facilities providing mainly custodial, educational or rehabilitative care; or
• sections of **hospitals** used for custodial, educational or rehabilitative care, even if accredited by the JCAHO or listed in the AHA directory.

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

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

**MAINTENANCE SERVICES** means any service that is intended to maintain current function, slow down, or prevent decline in function. Maintenance services are most often long term therapies that do not apply to persons with an acute chronic illness or functional deficit. See Section 4.35 - Supervision of Maintenance Therapy.

**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 plan year for certain covered health care services provided by network and non-network hospitals, facilities, doctors, and other health care providers. The network and non-network maximum out-of-pocket expenses add up separately.

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

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

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

**MEDICALLY NECESSARY** means that the health care services provided to treat your illness or injury, upon review by Blue Cross & Blue Shield of Rhode Island are:
• appropriate and effective for the diagnosis, treatment, or care of the condition, disease ailment or injury for which it is prescribed or performed;
• appropriate with regard to generally accepted standards of medical practice within the medical community or scientific evidence;
• not primarily for the convenience of the member, the member's family or provider of such member; AND
• the most appropriate in terms of type, amount, frequency, setting, duration, supplies or level of service which can safely be provided to the member, i.e. no less expensive professionally acceptable alternative is available.

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

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

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

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

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

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

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

PLAN means any hospital or medical service plan or health insurance benefit package provided by an organization. This includes an organization that is a member of the Blue Cross and Blue Shield Association and Blue Cross & Blue Shield of Rhode Island as well as:
• group insurance or group-type coverage, whether insured or self-insured, including group-type coverage through an HMO, other prepayment group practice or individual practice plan; AND
• coverage under a governmental plan or coverage required to be provided by law. This does not include a state plan under Medicaid (Title XIX, Grant to States for Medical Assistance Programs, of the U.S. Social Security Act as amended from time to time).

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

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

Preauthorization is the approval that we advise you to seek before receiving certain covered health care services. Selected prescription drugs bought at a pharmacy require prescription drug preauthorization. (See Section 3.27 for details.) Preauthorization ensures that services are medically necessary and performed in the most appropriate setting. Network providers are responsible for obtaining preauthorization for all applicable covered health care services. If a network provider does not obtain preauthorization, you are not liable for the cost of the covered health care service.

You are responsible for obtaining preauthorization when the provider is non-network or if the services are rendered by a provider or facility that participates with an out-of-state Blue Cross or Blue Shield plan (BlueCard). If you do not obtain preauthorization and the services are determined to be not medically necessary or the setting in which the services were received is determined to be inappropriate, we will not cover these services/facilities and you will be responsible for the cost of these services. You have the right to appeal our determination or to take legal action as described in Section 7.0.

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

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

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

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

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

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

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

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

See Section 3.33 - Speech Therapy and the Summary of Medical Benefits for *benefit limits* and the amount that you pay.

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

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

**SUBSCRIBER/MEMBER** means you and each *eligible person* listed on your application that is covered.

**SUBSTANCE ABUSE** 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 substance in order to function.

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

**SUBSTANCE ABUSE 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 *substance abuse* and *substance abuse* treatment, unless we can establish through a pre-admission certification process that services are not available at a facility that meets these requirements.

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

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

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

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

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