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 – Glossary, there is a list of definitions of words used throughout this agreement. It is very helpful to become familiar with these words and their definitions.
• Identification Cards (ID) are provided to all members. The ID card must be shown when obtaining health care services. Your ID card should be kept in a safe location, just like money, credit card or other important documents. BCBSRI should be notified immediately if your ID card is lost or stolen.
• Our list of network providers changes from time to time. You may want to call our Customer Service Department in advance to make sure that a provider is a network provider.
• You are encouraged to become involved in your health care treatment by asking providers about all treatment plans available and their costs. You also are encouraged to take advantage of the preventive health services offered under this agreement to help you stay healthy and find problems before they become serious.

IMPORTANT TELEPHONE NUMBERS AND WEBSITES

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

Our Website - www.BCBSRI.com.

Recommended Preauthorization

Services for which preauthorization is recommended are marked with an asterisk (*) in the Summary of Medical Benefits. Rhode Island network providers are responsible to obtain recommended preauthorization. Please see Section 1.6 for more information.
• Medical/Surgical - call our Customer Service Department. Please see Section 1.6 for details.
• Mental Health and Chemical Dependency - call 1-800-274-2958 before having care. Lines are open 24 hours a day, 7 days per week. Please see Section 1.6 for details.

Required Preauthorization

Prescription drugs for which preauthorization is required are marked with the symbol (+) in the Summary of Pharmacy Benefits. Please see Section 1.6 and Section 3.29 for more information.
• Prescription drugs - ask your prescribing physician to call the number listed for the “Pharmacist” on the back of your ID card. To see if 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 BENEFITS

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

IMPORTANT NOTE: All of our payments at the benefit levels noted below are based upon a fee schedule called our allowance. If you receive services from a network provider, the provider has agreed to accept our allowance as payment in full for covered health care services, excluding your copayments, deductible, and the difference between the maximum benefit and our allowance, if any. If you receive covered health care services from a non-network provider, 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.

<table>
<thead>
<tr>
<th>Dependent Age</th>
<th>See Section 2.1 – Who is Eligible for Coverage.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent Children</td>
<td>Children are covered until the first day of the month following their 26th birthday.</td>
</tr>
<tr>
<td>Network Provider</td>
<td>Non-Network Provider</td>
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</tr>
<tr>
<td>$250 per member per contract year</td>
<td>$1,000 per member per contract year</td>
</tr>
<tr>
<td>$500 per family per contract year</td>
<td>$2,000 per family per contract year</td>
</tr>
<tr>
<td>$750 per member per contract year</td>
<td>$3,000 per member per contract year</td>
</tr>
<tr>
<td>$1,500 per family per contract year</td>
<td>$6,000 per family per contract year</td>
</tr>
</tbody>
</table>

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

The contract year family deductible is met by adding the amount of covered health care expenses applied to the deductible for all family members; however no one (1) family member can contribute more than $250 towards the contract year family deductible.

The contract year family deductible is met by adding the amount of covered health care expenses applied to the deductible for all family members; however no one (1) family member can contribute more than $1,000 towards the contract year family deductible.

**Maximum Out-of-Pocket Expense** (Prescription drug copayments, flat dollar office visit copayments, and copayments for infertility services do not apply.)

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

The contract year family maximum out-of-pocket expense is met by adding the amount of covered health care expenses applied to the maximum out-of-pocket expense for all family members; however no one (1) family member can contribute more than $750 towards the contract year family maximum out-of-pocket expense.

The contract year family maximum out-of-pocket expense is met by adding the amount of covered health care expenses applied to the maximum out-of-pocket expense for all family members; however no one (1) family member can contribute more than $3,000 towards the contract year family maximum out-of-pocket expense.
<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Section</th>
<th>Benefit Limit</th>
<th>Network Provider</th>
<th>Non-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
<td>3.1</td>
<td></td>
<td></td>
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<tr>
<td>• Ground</td>
<td>3.1</td>
<td>100% coverage less $50 copayment per ambulance service. Deductible does not apply.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Air/water</td>
<td>3.1</td>
<td>Up to the maximum benefit of $3,000 per occurrence.</td>
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<tr>
<td>Behavioral Health</td>
<td>3.2</td>
<td></td>
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<tr>
<td>Mental Health Services</td>
<td>3.2</td>
<td></td>
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</tr>
<tr>
<td>• Inpatient *</td>
<td>3.2</td>
<td>Unlimited days at a general hospital or a specialty hospital.</td>
<td>After deductible 100% coverage</td>
<td>After deductible 80% coverage</td>
</tr>
<tr>
<td>• Outpatient, Intermediate Care Services *</td>
<td>3.2</td>
<td>See Section 3.2 for details about partial hospital program, intensive outpatient program, adult intensive services, and child and family intensive treatment.</td>
<td>After deductible 100% coverage</td>
<td>After deductible 80% coverage</td>
</tr>
<tr>
<td>• In a Provider’s office, or in your home</td>
<td>3.2</td>
<td>Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details. Includes individual and group sessions.</td>
<td>100% coverage less $15 copayment per visit by a personal physician, 100% coverage less $30 copayment per visit by a specialist. Deductible does not apply.</td>
<td>After deductible 80% coverage</td>
</tr>
<tr>
<td>Chemical Dependency Treatment</td>
<td>3.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient, Chemical Dependency Treatment Facility (inpatient)*</td>
<td>3.2</td>
<td>Detoxification – unlimited days Residential/Rehabilitation – unlimited days</td>
<td>After deductible 100% coverage</td>
<td>After deductible 80% coverage</td>
</tr>
<tr>
<td>• Outpatient, In a Chemical Dependency Treatment Facility (outpatient), Intermediate Care Services *</td>
<td>3.2</td>
<td>Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details. See Section 3.2 for details about partial hospital program, intensive outpatient program, adult intensive services, and child and family intensive treatment.</td>
<td>After deductible 100% coverage</td>
<td>After deductible 80% coverage</td>
</tr>
<tr>
<td>Type of Service</td>
<td>Section</td>
<td>Benefit Limit</td>
<td>Level of Coverage</td>
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</tr>
<tr>
<td>• In a Provider’s office, or in your home</td>
<td>3.2</td>
<td>Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details. Includes individual and group sessions.</td>
<td>100% coverage less $15 copayment per visit by a personal physician, 100% coverage less $30 copayment per visit by a specialist. Deductible does not apply. After deductible 80% coverage</td>
<td></td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>3.3</td>
<td>Benefit is limited to 18 weeks or 36 visits (whichever occurs first) per covered episode. See Section 3.3 for details.</td>
<td>100% coverage Deductible does not apply. After deductible 80% coverage</td>
<td></td>
</tr>
<tr>
<td>Chemotherapy Services</td>
<td>3.32</td>
<td>Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details.</td>
<td>After deductible 100% coverage After deductible 80% coverage</td>
<td></td>
</tr>
<tr>
<td>• Inpatient</td>
<td>3.32</td>
<td></td>
<td>After deductible 100% coverage After deductible 80% coverage</td>
<td></td>
</tr>
<tr>
<td>• Outpatient</td>
<td>3.32</td>
<td></td>
<td>After deductible 100% coverage After deductible 80% coverage</td>
<td></td>
</tr>
<tr>
<td>• In a doctor’s office</td>
<td>3.32</td>
<td>Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details.</td>
<td>After deductible 100% coverage After deductible 80% coverage</td>
<td></td>
</tr>
<tr>
<td>Chiropractic Medicine</td>
<td>3.4</td>
<td>12 visits per contract year.</td>
<td>100% coverage less $30 copayment per visit. Deductible does not apply. After deductible 80% coverage</td>
<td></td>
</tr>
<tr>
<td>Consultations in the Hospital</td>
<td>3.5</td>
<td>Must be requested by doctor in charge of your care.</td>
<td>After deductible 100% coverage After deductible 80% coverage</td>
<td></td>
</tr>
<tr>
<td>Contraceptive Drugs and Devices</td>
<td>3.6</td>
<td>Coverage varies based on type of contraceptive service. See Section 3.6. Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of Service</td>
<td>Section</td>
<td>Benefit Limit</td>
<td>Level of Coverage</td>
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<td></td>
<td>Network Provider</td>
<td>Non-Network Provider</td>
</tr>
<tr>
<td><strong>Diabetic Services</strong></td>
<td>3.7</td>
<td>See Section 3.7 for limitations.</td>
<td>After deductible 80% coverage</td>
<td>After deductible 80% coverage</td>
</tr>
<tr>
<td>• Diabetic equipment/</td>
<td>3.7</td>
<td>See Section 3.7 for limitations.</td>
<td></td>
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<tr>
<td>supplies provided by a licensed medical supply provider (other than a pharmacy).</td>
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<tr>
<td>• Diabetic equipment/</td>
<td>3.7</td>
<td>See the Summary of Pharmacy Benefits for benefit limits and level of coverage.</td>
<td>After deductible 80% coverage</td>
<td>After deductible 80% coverage</td>
</tr>
<tr>
<td>supplies purchased at a retail pharmacy.</td>
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</tr>
<tr>
<td><strong>Office visits</strong></td>
<td>3.7</td>
<td>Podiatrist Services</td>
<td>100% coverage</td>
<td>After deductible 80% coverage</td>
</tr>
<tr>
<td>First routine visit of a contract year. See Section 3.7 for details.</td>
<td></td>
<td></td>
<td>Deductible does not apply.</td>
<td></td>
</tr>
<tr>
<td><strong>Vision Care Service</strong></td>
<td>3.7</td>
<td>100% coverage Deductible does not apply.</td>
<td>After deductible 80% coverage</td>
<td>After deductible 80% coverage</td>
</tr>
<tr>
<td>First routine eye exam of a contract year that includes a retinal eye exam.</td>
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<tr>
<td><em><em>Diagnostic Imaging</em>, Lab, and Machine Tests</em>*</td>
<td>3.8</td>
<td>Preauthorization is recommended for certain diagnostic imaging services. See Section 3.8 for details.</td>
<td>100% coverage Deductible does not apply.</td>
<td>After deductible 80% coverage</td>
</tr>
<tr>
<td>See Section 3.8 for benefit limitations.</td>
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</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td>3.8</td>
<td>After deductible 100% coverage</td>
<td>After deductible 80% coverage</td>
<td>After deductible 80% coverage</td>
</tr>
<tr>
<td><strong>Outpatient Hospital Facility</strong></td>
<td>3.8</td>
<td>After deductible 100% coverage</td>
<td>After deductible 80% coverage</td>
<td>After deductible 80% coverage</td>
</tr>
<tr>
<td><strong>Outpatient Non-Hospital facility including in a Doctor’s office, urgent care center, or free-standing laboratory</strong></td>
<td>3.8</td>
<td>See Section 3.8 for limitations.</td>
<td>After deductible 100% coverage</td>
<td>After deductible 80% coverage</td>
</tr>
<tr>
<td><strong>Diagnostic hearing tests</strong></td>
<td>3.8</td>
<td>100% coverage Deductible does not apply.</td>
<td>After deductible 80% coverage</td>
<td>After deductible 80% coverage</td>
</tr>
<tr>
<td><strong>Doctor’s Hospital Visits</strong></td>
<td>3.9</td>
<td>After deductible 100% coverage</td>
<td>After deductible 80% coverage</td>
<td>After deductible 80% coverage</td>
</tr>
<tr>
<td><strong>Early Intervention Services (EIS)</strong></td>
<td>3.10</td>
<td>Up to the maximum benefit of $5,000 per child, from birth to 36 months, per contract year. The provider must be certified as an EIS provider by the Rhode Island Department of Human Services.</td>
<td>100% coverage Deductible does not apply.</td>
<td>100% coverage Deductible does not apply.</td>
</tr>
</tbody>
</table>

Summary of Benefits
SUMMARY GRP (09-10)
<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Section</th>
<th>Benefit Limit</th>
<th>Level of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room Services</td>
<td>3.11</td>
<td>100% coverage less $100 copayment. ER copayment waived if admitted as a hospital inpatient within 24 hours. Deductible does not apply.</td>
<td>The level of coverage is the same as network provider.</td>
</tr>
<tr>
<td>Experimental/ Investigational Services</td>
<td>3.12</td>
<td>Coverage varies based on type of service. See Section 3.12.</td>
<td></td>
</tr>
<tr>
<td>Hemodialysis Services</td>
<td>3.13</td>
<td>• Inpatient After deductible 100% coverage After deductible 80% coverage</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Outpatient After deductible 100% coverage After deductible 80% coverage</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• In your home After deductible 100% coverage After deductible 80% coverage</td>
<td></td>
</tr>
<tr>
<td>Hemophilia Services</td>
<td>3.14</td>
<td>• Outpatient After deductible 100% coverage After deductible 80% coverage</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• In a Doctor’s Office 100% coverage less $30 copayment per visit. Deductible does not apply.</td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>3.15</td>
<td>Intermittent skilled services when billed by a home health care agency. 100% coverage less $30 copayment per visit. Deductible does not apply.</td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>3.16</td>
<td>When provided by an approved hospice care program. 100% coverage</td>
<td></td>
</tr>
<tr>
<td>Type of Service</td>
<td>Section</td>
<td>Benefit Limit</td>
<td>Level of Coverage</td>
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</tr>
<tr>
<td>Hospital Services *</td>
<td>3.17</td>
<td>Unlimited days at a general hospital or a specialty hospital; maximum of 45 days per contract year for physical rehabilitation.</td>
<td>Network Provider 100% coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Non-Network Provider 80% coverage</td>
</tr>
<tr>
<td>House Calls</td>
<td>3.18</td>
<td>See Section 3.2 - Behavioral Health for benefit information regarding house calls for behavioral health.</td>
<td>Network Provider 100% coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Non-Network Provider 80% coverage</td>
</tr>
<tr>
<td>Human Leukocyte Antigen Testing</td>
<td>3.19</td>
<td>See Section 3.19 for limitations.</td>
<td>Network Provider 100% coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Non-Network Provider 80% coverage</td>
</tr>
<tr>
<td>Infertility Services</td>
<td>3.20</td>
<td>Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details.</td>
<td>Network Provider 80% coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Non-Network Provider 80% coverage</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>3.21</td>
<td></td>
<td>Network Provider 100% coverage</td>
</tr>
<tr>
<td>• Inpatient</td>
<td>3.21</td>
<td>Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details.</td>
<td>Non-Network Provider 80% coverage</td>
</tr>
<tr>
<td>• Outpatient</td>
<td>3.21</td>
<td>Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details.</td>
<td>Network Provider 100% coverage</td>
</tr>
<tr>
<td>• In the Doctor's office, or In your</td>
<td>3.21</td>
<td>Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details.</td>
<td>Non-Network Provider 80% coverage</td>
</tr>
<tr>
<td>home</td>
<td></td>
<td></td>
<td>Network Provider 100% coverage</td>
</tr>
<tr>
<td>Lyme Disease Diagnosis and Treatment</td>
<td>3.22</td>
<td>Coverage varies based on type of service. See Section 3.22.</td>
<td>Network Provider 100% coverage</td>
</tr>
<tr>
<td>Medical Equipment*, Medical Supplies,</td>
<td>3.23</td>
<td>Preauthorization is recommended for certain services. See Section 3.23 for details.</td>
<td>Non-Network Provider 80% coverage</td>
</tr>
<tr>
<td>Enteral Formula and Food, and Prosthetic Devices</td>
<td></td>
<td></td>
<td>Network Provider 80% coverage</td>
</tr>
<tr>
<td>• Inpatient</td>
<td>3.23</td>
<td>After deductible 100% coverage</td>
<td>Non-Network Provider 80% coverage</td>
</tr>
<tr>
<td>• Outpatient</td>
<td>3.23</td>
<td>After deductible 80% coverage</td>
<td>Network Provider 80% coverage</td>
</tr>
<tr>
<td>Type of Service</td>
<td>Section</td>
<td>Benefit Limit</td>
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<tr>
<td>- Enteral formula</td>
<td>3.23</td>
<td>Must be sole source of nutrition.</td>
<td>After deductible 80% coverage</td>
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<tr>
<td>delivered through</td>
<td></td>
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<td>After deductible 80% coverage</td>
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<tr>
<td>a feeding tube</td>
<td></td>
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<tr>
<td>- Enteral formula or</td>
<td>3.23</td>
<td>Benefit is limited to a maximum benefit of $2,500 per member per contract year.</td>
<td>After deductible 80% coverage</td>
</tr>
</tbody>
</table>
| food taken orally*                    |         | See Section 3.23 for details.                                                 | The level of coverage is the same as network provider.
|                                      |         |                                                                                |                                                  |
| - Hearing Aid                         | 3.23    | For an eligible person under the age of 19; coverage is limited to the maximum benefit of $1,500 per ear, per 3-year period per member. | After deductible 80% coverage                     |
|                                      |         | See Section 3.23 for details.                                                 | The level of coverage is the same as network provider.
|                                      |         | For an eligible person age 19 and over; coverage is limited to the maximum benefit of $700 per ear, per 3-year period per member. | After deductible 80% coverage                     |
| - Hair Prosthesis                     | 3.23    | Benefit is limited to the maximum benefit of $350 per member per contract year when worn for hair loss suffered as a result of cancer treatment. | After deductible 80% coverage                     |
| (Wigs)                                |         |                                                                                | The level of coverage is the same as network provider.
|                                      |         |                                                                                |                                                  |
| Office Visits                         | 3.24    | Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.29 - Prescription Drugs for details. | After deductible 80% coverage                     |
|                                      |         | See Section 3.2 - Behavioral Health for level of coverage for office visits related to mental health and chemical dependency services. | The level of coverage is the same as network provider.
<p>| - Allergist and Dermatologist         | 3.24    | 100% coverage less $30 copayment per visit. Deductible does not apply.         | After deductible 80% coverage                     |
| - Asthma Education                    | 3.24    | 100% coverage Deductible does not apply.                                      | After deductible 80% coverage                     |
| - Diabetes Education                  | 3.24    | Individual and group sessions are covered.                                    | 100% coverage Deductible does not apply.          |
|                                      |         |                                                                                | After deductible 80% coverage                     |</p>
<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Section</th>
<th>Benefit Limit</th>
<th>Network Provider</th>
<th>Non-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based Clinic Visits</td>
<td>3.24</td>
<td>100% coverage less $30 copayment per visit at a hospital based clinic.</td>
<td>After deductible</td>
<td>80% coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible does not apply.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>3.24</td>
<td>Unlimited visits per contract year when prescribed by a physician.</td>
<td>100% coverage</td>
<td>After deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible does not apply.</td>
<td></td>
<td>80% coverage</td>
</tr>
<tr>
<td>Office Visits (other than Pediatric</td>
<td>3.24</td>
<td>One routine adult physical examination and one routine gynecological examination per contract year per member will be covered.</td>
<td>100% coverage</td>
<td>After deductible</td>
</tr>
<tr>
<td>Office Visits (other than Pediatric</td>
<td></td>
<td>Deductible does not apply.</td>
<td></td>
<td>80% coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sick Visit</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>100% coverage less $15 copayment per visit by a personal physician.</td>
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<td></td>
<td></td>
<td>Deductible does not apply.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>After deductible</td>
<td></td>
<td>80% coverage</td>
</tr>
<tr>
<td>Pediatric Office Visits</td>
<td>3.24</td>
<td>Well-Child Office Visits: Birth - 15 months: 8 visits</td>
<td>100% coverage</td>
<td>After deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>16 - 35 months: 3 visits36 months - 19 years: 1 per contract year.</td>
<td></td>
<td>80% coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sick visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>100% coverage less $15 copayment per visit.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Deductible does not apply.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>After deductible</td>
<td></td>
<td>80% coverage</td>
</tr>
<tr>
<td>Specialist Visits</td>
<td>3.24</td>
<td>Routine and non-routine visits.</td>
<td>100% coverage</td>
<td>After deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible does not apply.</td>
<td></td>
<td>80% coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>See Section 3.2 for benefit information regarding behavioral health.</td>
<td></td>
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</tr>
<tr>
<td>Urgent Care Center Visits</td>
<td>3.24</td>
<td>See Section 8.0 – definition of urgent care center.</td>
<td>100% coverage</td>
<td>The level of coverage is the same as network provider.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible does not apply.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>After deductible</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>100% coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organ Transplants *</td>
<td>3.25</td>
<td>See Section 3.25 for detailed information.</td>
<td>After deductible</td>
<td>After deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100% coverage</td>
<td></td>
<td>80% coverage</td>
</tr>
<tr>
<td>Type of Service</td>
<td>Section</td>
<td>Benefit Limit</td>
<td>Network Provider</td>
<td>Non-Network Provider</td>
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<td>-----------------------------------------</td>
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</tr>
<tr>
<td>Physical/Occupational Therapy</td>
<td>3.26</td>
<td></td>
<td>After deductible</td>
<td>After deductible</td>
</tr>
<tr>
<td>• Inpatient</td>
<td>3.26</td>
<td>100% coverage</td>
<td>80% coverage</td>
<td></td>
</tr>
<tr>
<td>• Outpatient /in a doctor’s/therapist’s office</td>
<td>3.26</td>
<td>After deductible</td>
<td>80% coverage</td>
<td></td>
</tr>
<tr>
<td>Podiatrist Services</td>
<td>3.27</td>
<td>See Section 3.27 for routine foot care exclusions.</td>
<td>100% coverage less $30 copayment per visit. Deductible does not apply.</td>
<td>After deductible 80% coverage</td>
</tr>
<tr>
<td>Pregnancy Services and Nursery Care</td>
<td>3.28</td>
<td>Includes pre-natal, delivery, and postpartum services.</td>
<td>After deductible 100% coverage</td>
<td>After deductible 80% coverage</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>3.29</td>
<td>See Section 3.29 - Prescription Drugs for details.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medications other than injected drugs or infused drugs</td>
<td>3.29</td>
<td>Medications are included in the allowance for the medical service being rendered. Includes chemotherapy drugs used for other than cancer treatment.</td>
<td>After deductible 100% coverage</td>
<td>After deductible 80% coverage</td>
</tr>
<tr>
<td>• injectable drugs</td>
<td>3.29</td>
<td>After deductible 100% coverage</td>
<td>After deductible 80% coverage</td>
<td></td>
</tr>
<tr>
<td>• infused drugs</td>
<td>3.29</td>
<td>After deductible 100% coverage</td>
<td>After deductible 80% coverage</td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs Purchased at a Retail, Specialty, or Mail Order Pharmacy</td>
<td>3.29</td>
<td>See Summary of Pharmacy Benefits for benefit limits and level of coverage.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention and Early Detection Services</td>
<td>3.30</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. See Section 3.30 for benefit details and limitations.</td>
<td>100% coverage Deductible does not apply.</td>
<td>After deductible 80% coverage</td>
</tr>
<tr>
<td>Type of Service</td>
<td>Section</td>
<td>Benefit Limit</td>
<td>Network Provider</td>
<td>Non-Network Provider</td>
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</tr>
<tr>
<td>Adult Immunizations</td>
<td>3.30</td>
<td>100% coverage</td>
<td>After deductible</td>
<td>80% coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible does not apply.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric Immunizations</td>
<td>3.30</td>
<td>100% coverage</td>
<td>After deductible</td>
<td>80% coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible does not apply.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel Immunizations</td>
<td>3.30</td>
<td>100% coverage</td>
<td>After deductible</td>
<td>80% coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible does not apply.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Duty Nursing *</td>
<td>3.31</td>
<td>After deductible</td>
<td>After deductible</td>
<td>80% coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100% coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>3.32</td>
<td>After deductible</td>
<td>After deductible</td>
<td>80% coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100% coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>3.32</td>
<td>After deductible</td>
<td>After deductible</td>
<td>80% coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100% coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>3.32</td>
<td>After deductible</td>
<td>After deductible</td>
<td>80% coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100% coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>3.33</td>
<td>See program requirements in Section 3.33.</td>
<td>After deductible</td>
<td>80% coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100% coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Care in a Nursing Facility *</td>
<td>3.34</td>
<td>After deductible</td>
<td>After deductible</td>
<td>80% coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100% coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking Cessation Programs</td>
<td>3.35</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling</td>
<td>3.35</td>
<td>100% coverage</td>
<td>After deductible</td>
<td>80% coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible does not apply.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nicotine replacement therapy and smoking cessation prescription drugs</td>
<td>3.35</td>
<td>See the Summary of Pharmacy Benefits for level of coverage.</td>
<td>After deductible</td>
<td>80% coverage</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>3.36</td>
<td>After deductible</td>
<td>After deductible</td>
<td>80% coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100% coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient*</td>
<td>3.36</td>
<td>After deductible</td>
<td>After deductible</td>
<td>80% coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>80% coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a doctor’s/therapist’s office*</td>
<td>3.36</td>
<td>After deductible</td>
<td>After deductible</td>
<td>80% coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>80% coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery Services</td>
<td>3.37</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>3.37</td>
<td>After deductible</td>
<td>After deductible</td>
<td>80% coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100% coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient/Free-standing Ambulatory Surgery Center</td>
<td>3.37</td>
<td>After deductible</td>
<td>After deductible</td>
<td>80% coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100% coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of Service</td>
<td>Section</td>
<td>Benefit Limit</td>
<td>Network Provider</td>
<td>Non-Network Provider</td>
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</tr>
<tr>
<td>In a doctor’s office</td>
<td>3.37</td>
<td>100% coverage, Deductible does not apply.</td>
<td>After deductible</td>
<td></td>
</tr>
<tr>
<td>Vision Care Services</td>
<td>3.38</td>
<td>100% coverage less $30 copayment per visit.</td>
<td>After deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible does not apply.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>One routine eye exam per contract year.</td>
<td></td>
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</tr>
</tbody>
</table>
Only applies to the Summary of Pharmacy Benefits:

(+) Preauthorization is required for certain brand name prescription drugs and certain specialty prescription drugs. If preauthorization is not obtained, you will be required to pay for the prescription drug at the pharmacy. You can ask us to consider reimbursement after you receive the prescription drug by following the prescription drug preauthorization process. For details on how to obtain prescription drug preauthorization for a prescription drug, see Section 3.29. For a list of prescription drugs that require preauthorization, visit our Web site at BCBSRI.com or call our Customer Service Department at (401) 459-5000 or 1-800-639-2227.

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

**Tier 1** – generally low cost generic drugs;

**Tier 2** – generally high cost generic and preferred brand name drugs;

**Tier 3** – other generic and non-preferred brand name drugs; and

**Tier 4** – specialty prescription drugs.

The Summary of Pharmacy Benefits below indicates the tier structure and the corresponding level of coverage. The tier placement of our formulary is subject to change.

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

For information about prescription drugs, please see Section 3.29. Included in Section 3.29 are definitions about your Pharmacy Benefits.

<table>
<thead>
<tr>
<th>Type and Site of Service</th>
<th>Section</th>
<th>Benefit Limit</th>
<th>Tiers</th>
<th>Network Pharmacy</th>
<th>Non-Network Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Drugs, other than Specialty Prescription Drugs</td>
<td>3.29</td>
<td></td>
<td>3.29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>when purchased at a Retail or Specialty Pharmacy</td>
<td>3.29</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>100% coverage less your copayment of $10</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Tier 2</td>
<td>100% coverage less your copayment of $35</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Tier 3</td>
<td>100% coverage less your copayment of $60</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Tier 4</td>
<td>See specialty prescription drug section below.</td>
<td>See specialty prescription drug section below.</td>
</tr>
<tr>
<td>Type of Service</td>
<td>Section</td>
<td>Benefit Limit</td>
<td>Level of Coverage</td>
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</tr>
<tr>
<td>• when purchased at a Mail Order Pharmacy</td>
<td>3.29</td>
<td>Up to a 90-day supply of maintenance and non-maintenance prescription drugs.</td>
<td>Tier 1: 100% coverage less your copayment of $25</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Tier 2: 100% coverage less your copayment of $87.50</td>
<td>Not Covered</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Tier 3: 100% coverage less your copayment of $150</td>
<td>Not Covered</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Tier 4: See specialty prescription drug section below.</td>
<td>See specialty prescription drug section below</td>
<td></td>
</tr>
<tr>
<td>• Infertility</td>
<td>3.29</td>
<td></td>
<td>Tier 1: 80% coverage</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Prescription drugs, purchased at any Pharmacy</td>
<td></td>
<td></td>
<td>Tier 2: 80% coverage</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Tier 3: 80% coverage</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Tier 4: See specialty prescription drug section below</td>
<td>See specialty prescription drug section below</td>
<td></td>
</tr>
<tr>
<td>• Diabetes, Asthma, and COPD prescription drugs</td>
<td>3.29</td>
<td>Member must be being treated for certain health conditions</td>
<td>100% coverage less your copayment of $2.</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>• Over-the-counter (OTC) preventive drugs, purchased at any pharmacy</td>
<td>3.29</td>
<td>Must be prescribed by a physician. See Section 3.29 for details.</td>
<td>100% coverage</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>• Nicotine Replacement Therapy and Smoking Cessation Prescription Drugs, purchased at a Retail or Specialty Pharmacy.</td>
<td>3.29</td>
<td>Must be prescribed by a physician. See Section 3.29 for details.</td>
<td>100% coverage</td>
<td>Not Covered</td>
<td></td>
</tr>
</tbody>
</table>
### Specialty Prescription Drugs

- **when purchased at a Specialty Pharmacy**
  - Copayment applies per each 30-day supply or applies per recommended treatment interval.
  - **Tier 4**
    - 100% coverage less your copayment of $100 (+)
    - You are responsible to pay the lower of your copayment or the retail price of the drug.
  - **Non-Network Pharmacy**
    - 50% coverage
      - Our reimbursement is based on the pharmacy allowance. You are responsible to pay up to the retail cost of the drug.

- **when purchased at a Retail Pharmacy**
  - Specialty Prescription Drugs purchased at a Retail Pharmacy are reimbursed at the non-network level of coverage.
  - **Tier 4**
    - 50% coverage
      - Our reimbursement is based on the pharmacy allowance. You are responsible to pay up to the retail cost of the drug.
  - **Non-Network Pharmacy**
    - 50% coverage
      - Our reimbursement is based on the pharmacy allowance. You are responsible to pay up to the retail cost of the drug.

- **when purchased at a Mail Order Pharmacy**
  - **Tier 4**
    - Not Covered
      - Not Covered

- **Infertility specialty prescription drugs purchased at a Specialty Pharmacy (+)**
  - Specialty Prescription Drugs purchased at a Retail Pharmacy are reimbursed at the non-network level of coverage.
  - **Tier 4**
    - 80% (+) coverage
      - Your copayment is based on the lower of our allowance or the retail cost of the prescription drug.
    - 80% (+) coverage
      - Our reimbursement is based on the pharmacy allowance. You are responsible to pay up to the retail cost of the drug.

- **Infertility specialty prescription drugs purchased at a Retail Pharmacy(+)**
  - Specialty Prescription Drugs purchased at a Retail Pharmacy are reimbursed at the non-network level of coverage.
  - **Tier 4**
    - 80% (+) coverage for Specialty Prescription Drugs.
      - Our reimbursement is based on the pharmacy allowance. You are responsible to pay up to the retail cost of the drug.
    - 80% (+) coverage for Specialty Prescription Drugs.
      - Our reimbursement is based on the pharmacy allowance. You are responsible to pay up to the retail cost of the drug.

### Diabetic equipment and supplies

- **when purchased at a Retail or Specialty Pharmacy**
  - Glucometers, Test Strips, Lancet and Lancet Devices, and Miscellaneous Supplies (including calibration fluid).
    - You are responsible to pay the lower of your copayment or the retail price of the drug.
  - **Tier 1**
    - 100% coverage less your copayment of $10
    - Not Covered
  - **Tier 2**
    - 100% coverage less your copayment of $35
    - Not Covered
  - **Tier 4**
    - Diabetic equipment and supplies are only placed in Tier 1 or Tier 2. See above.
<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Section</th>
<th>Benefit Limit</th>
<th>Level of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>• when purchased at a Mail Order Pharmacy</td>
<td>3.29</td>
<td>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.</td>
<td>Tier 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Tier 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Tier 3</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>
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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. We will make a determination regarding your eligibility for benefits and construe the provisions of this agreement subject to your right to appeal or to take legal action as described in Section 7.0.

This agreement may be changed by us or by your employer/agent. 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 your employer/agent.

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

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

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

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

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

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

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

- final FDA approval;
- the assignment of processing codes other than CPT codes or approval by governing or regulatory bodies other than the FDA;
- submission to us of a claim meeting the criteria of (a), (b) or (c) above; and
- the first date generally available in pharmacies (for prescription drugs only).

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

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

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

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

1.5 Customer Service/General Information

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

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

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

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

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

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

1.6 Completion of a Personal Health Assessment
If you and your enrolled spouse complete a personal health assessment (PHA), each of you will receive from us an award payment for completing the PHA. You and your spouse must be eighteen (18) years old or older to complete a PHA. We reserve the right to terminate this program at any time. To find out more information, please visit our Web site at BCBSRI.com or contact our Customer Service Department.

1.7 Preauthorization
Services for which preauthorization is recommended are marked with an asterisk (*) in the Summary of Medical Benefits. Preauthorization is defined in Section 8.0. To obtain preauthorization for a covered health care service:

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

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

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

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

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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 preauthorization. Prescription drug preauthorization is defined in Section 3.29.

1.8 Our Right to Receive and Release Information About You
We are committed to maintaining the confidentiality of your health care information. 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.


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

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

The determination by us of whether to cover an alternative benefit is solely for the purpose of claims payment and the administration of health benefits under this agreement. Your treatment remains a decision made by you with your doctor. Any decision to cover or not to cover alternative benefits is within our sole discretion. Any decision not to approve alternative benefits made by us in good faith is binding upon you.
If we approve an alternative benefit, you must verbally agree to our specific terms and conditions. You must sign a letter of agreement acknowledging acceptance of the specific terms and conditions of the alternative benefits.

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

1.10 Our Right to Conduct Utilization Review
To be sure a member receives appropriate benefits; we reserve the right to do utilization review. We also reserve the right to contract with an organization to conduct utilization review on our behalf. If another company does utilization review on our behalf, the company will act as an independent contractor. The company is not a partner, agent, or employee of 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).

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

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

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

1.12 How to Select a Health Care Provider
When you select a health care provider, refer to the Provider Network Directory to find out if your health care provider is a 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.

1.13 Your Responsibility To Pay Your Providers

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

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

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

2.1 **Who is an Eligible Person**

**You:** 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.
- Former Spouse: In the event of a divorce, your former spouse will continue to be eligible for coverage provided that your divorce decree requires you to maintain continuing coverage under a family policy in accordance with state law. In that case, your former spouse will remain eligible on your policy until the earlier of:
  i. the date either you or your former spouse are remarried;
  ii. the date provided by the judgment for divorce; or
  iii. the date your former spouse has comparable coverage available through his or her own employment.
- Domestic Partner: 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.

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

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

We may request more information from you to confirm your child’s eligibility.

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

If you have an unmarried child of any age who is medically certified as disabled and is chiefly dependent on you for support and care because of mental impairment or physical disability, which can be expected to result in death or can be expected to last for a continuous period of not less 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 First Eligible
When you are first eligible, you and your eligible dependents may enroll by making written application to us through your employer/agent for coverage within the first thirty-one (31) days 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.

Open Enrollment
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 making written 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 after you experience a change in family status, a loss of private health coverage, or a change in eligibility for Medicaid or a State Children’s Health Insurance Program (CHIP) as described below.

With a change in family status, you must make written application within the thirty-one (31) days following the event. You and/or your eligible dependents will qualify for a Special Enrollment Period as follows:
• if you get married, coverage begins the first day of the month following your marriage;
• if you have a child born to the family, coverage begins on the date of the child’s birth;
• if you have a child placed for adoption with your family, coverage begins on the date the child is placed for adoption with your family.

With a loss of private health coverage, you must make written application within the thirty-one (31) days following the event. Coverage begins the first day of the month following the loss of private health coverage. If you or your eligible dependents have a loss of coverage on the first day of the month, coverage under this plan begins on the first day of that month. You or your eligible dependents will qualify for a Special Enrollment Period if each of the following conditions is met:
• The eligible person seeking coverage had other coverage at the time that he or she was first eligible for coverage under this agreement;
• The person waived coverage under this plan due to being covered on another plan; and
• The coverage on the other plan is terminated as a result of:
  • loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment),
  • employer contributions towards such coverage being terminated, or
  • COBRA, due to continuation, is exhausted.

With a change in eligibility for Medicaid or a CHIP, you must make written application within sixty (60) days following your change in eligibility. Coverage will begin on either the first day of the month following the event or, if the event occurs on the first day of a month, coverage under this plan begins on the first day of that month. You and/or your eligible dependents will qualify for a Special Enrollment Period as follows:
• you and/or your eligible dependent are terminated from Medicaid or CHIP coverage due to a loss of eligibility; or
• you and/or your eligible dependent become eligible for premium assistance, under your employer/agent’s coverage, through Medicaid or CHIP.

Coverage for Members who are Hospitalized on their Effective Date
If you are in the hospital on your effective date of coverage, health care services related to such hospitalization are covered as long as: (a) you notify us of your hospitalization within forty-eight (48) hours of the effective date, or as soon as is reasonably possible; and (b) covered health care services are received in accordance with the terms, conditions, exclusions and limitations of this agreement. As always, benefits paid in such situations are subject to the Coordination of benefits provisions described in Section 6.0.
Late Enrollment: You and/or your eligible dependents may enroll following the initial enrollment period, and outside of the open enrollment or special enrollment periods. Coverage is effective the first day of the calendar month following the receipt of your completed application.

2.3 How to Add or Remove Coverage for Family Members
You must notify 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
This agreement will end:

- if you leave your place of work;
- if you decide to discontinue coverage. We must receive your notice to end this agreement prior to the requested date of cancellation. If we do not receive your notice prior to the requested date of cancellation, you 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 thirty-one (31) days 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;
- 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. You will NOT be offered membership in our direct pay plan;
- 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. You will NOT be offered membership in our direct pay plan; 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.

You will NOT be offered membership in our direct pay plan.
This *agreement* will end for a covered dependent if the dependent no longer qualifies as an eligible dependent.

Except as noted above, you will be entitled to apply for direct pay membership from Blue Cross & Blue Shield of Rhode Island. You must meet the eligibility requirements. We must receive an application and membership fees within thirty-one (31) 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 reduce a pre-existing condition exclusion period, obtain a special enrollment under a new plan, or get certain types of individual health coverage even if you have a health condition.

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

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 1.2 for how we identify new services and our guidelines for reviewing and making coverage determinations.

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

The amount of coverage we provide for each health care service differs according to whether or not the service is received:
• as an inpatient;
• as an outpatient;
• in your home;
• in a doctor’s office; or
• from a pharmacy.

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

Please see the Summary of Benefits at the front of this agreement to determine the benefit limits and level of coverage we provide for the covered health care services in this agreement.

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

Local professional or municipal ground ambulance services are covered when it is medically necessary to use these services, rather than any other form of transportation, to these places:
• to the closest available hospital for an inpatient admission;
• from a hospital to home or to a skilled nursing facility or to a rehabilitation facility after being discharged as an inpatient;
• to the closest available hospital emergency room immediately in an emergency;
• to and from a hospital for medically necessary services not available in the facility where you are an inpatient; or
• from a physician’s office to a skilled nursing facility.
Our allowance for the ground ambulance includes the services rendered by an emergency medical technician or paramedic, drugs, supplies and cardiac monitoring.

**Related Exclusion**
This agreement does NOT cover ground ambulance transportation to a physician’s office.

**Air and Water Ambulance**
*Medically necessary* air and water ambulance services are covered as listed in the Summary of Benefits.

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

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

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

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

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

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

**Related Exclusions**
This agreement does NOT provide coverage for:
- air or water ambulance transportation unless the destination is an acute care hospital. (some examples of non-covered air or water ambulance services include transport to a physician’s office, nursing facility, or a patient’s home); and
- transport from cruise ships when not in United States waters.
3.2 Behavioral Health Services

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

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

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

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

A. Mental Health Services

Inpatient

If you are an inpatient in a general or specialty hospital for mental health services, we cover medically necessary hospital services and the services of an attending physician. See Section 3.16 - Hospital Services for additional information.

Outpatient/Intermediate Care Services

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

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

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

- Intensive Outpatient Program (IOP) – We cover intensive outpatient programs that are approved by us and meet our criteria for participation. This program must be available for a minimum of three (3) hours per day, three (3) days per week. It must consist of, but not limited to, individual, group, and family therapy, medication evaluation and management services. It must be available 24 hours a day 7 days per week for support of the patient. This program must provide substantial clinical support for patients who are either in transition from the hospital to an outpatient setting or at risk for admission to inpatient care or other higher levels of care.
• **Adult Intensive Service (AIS)** – We cover adult intensive services that are approved by us and meet our criteria for participation. AIS is a facility based mental health care program. Adult intensive services are primarily based in the home for qualifying adults with moderate to severe psychiatric conditions. This program must consist of, but is not limited to, the following:
  • ongoing emergency or crisis evaluations that are available 24 hours a day 7 days per week;
  • psychiatric assessment;
  • medication evaluation and management;
  • case management;
  • psychiatric nursing services; and
  • individual, group, and family therapy.

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

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

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

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

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

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

We cover medication visits as an office visit when rendered by a psychiatrist or a clinical nurse specialist in behavioral health. See Section 3.24 - Office Visits.
For prescription drug coverage, see Section 3.29 - Prescription Drugs and Diabetic Equipment/Supplies. See the Summary of Pharmacy Benefits for benefit limits and level of coverage.

**Electroconvulsive Therapy**
We cover electroconvulsive therapy (ECT) services when performed and billed by a psychiatrist. We cover anesthesia services when rendered by an anesthesiologist. See Section 3.37 Surgery Services - Anesthesia Services.

**Related Exclusions**
This agreement does NOT cover the following mental health services:
- Recreation therapy, non-medical self-care, or self-help training;
- Mental health residential treatment programs (including eating disorder residential treatment programs) and mental health services performed in a residential treatment facility or in the portion of a hospital, or any inpatient facility, used for residential treatment purposes. We review the program, hospital or inpatient facility and the specific services provided to decide whether a program, hospital or inpatient facility meets our medical guidelines and criteria;
- Telephone consultations (See Section 4.16);
- Therapeutic recreation programs or wilderness programs;
- Services provided in any covered program that are reviewed by us and we decide are recreation therapy programs, wilderness programs, or non-clinical services; and
- Behavioral training assessment, education or exercises, including applied behavioral analysis.

This agreement does NOT cover mental health services when:
- the provider does NOT meet the eligibility and/or credentialing requirements; or
- the program is not approved by us.

This agreement does NOT cover treatment at facilities that are not approved and/or licensed by the state in which the facility is located. See Section 4.6 for Services Provided by Facilities We Have Not Approved and Section 4.8 for Services Performed by People/Facilities Who Are Not Legally Qualified or Licensed.

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

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

In order for a facility to be a network provider, the facility must meet specific requirements including, but not limited to, the following:
- The provider must be licensed under the laws of the State of Rhode Island or by the state in which the facility is located as a hospital, a chemical dependency treatment facility, or a community residential facility for chemical dependency treatment; AND
- The provider must sign an agreement to provide covered chemical dependency services.
Related Exclusions
This agreement does NOT cover chemical dependency services provided in any covered program that are reviewed by us and we decide are recreation therapy programs, wilderness programs, or non-clinical services. We review the program, hospital or inpatient facility and the specific services provided to decide whether a program, hospital or inpatient facility meets our medical guidelines and criteria.

This agreement does NOT cover chemical dependency treatment when:
• the provider does NOT meet the eligibility and/or credentialing requirements; or
• the program is not approved by us.

This agreement does NOT cover treatment at facilities that are not approved and/or licensed by the state in which the facility is located. See Section 4.6 for Services Provided by Facilities We Have Not Approved and Section 4.8 for Services Performed by People/Facilities Who Are Not Legally Qualified or Licensed.

Inpatient/Chemical Dependency Treatment Facility
We cover the following inpatient chemical dependency services:
• Inpatient detoxification as shown in the Summary of Benefits.
• Acute Rehabilitation or Residential treatment as shown in the Summary of Benefits.

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

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

We cover the following chemical dependency Intermediate Care Services:

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

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

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

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

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

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

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

**Related Exclusions**
This agreement does NOT cover methadone clinics and treatments. See Section 4.6 - Services Provided By Facilities We Have Not Approved and Section 4.8 - Services Performed by People/Facilities Who Are Not Legally Qualified or Licensed.

**3.3 Cardiac Rehabilitation**

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

For information about medical equipment and supplies, see Section 3.23 - Medical Equipment, Medical Supplies, and Prosthetic Devices.

**Related Exclusions**
This *agreement* does NOT cover:
- massage therapy, aqua therapy, maintenance therapy, and aromatherapy;
- therapies, procedures, and services for the purpose of relieving stress;
- pillows;
- x-rays read by a chiropractic physician; and
- chiropractic services received in your home.

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

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

3.6 **Contraceptive Drugs and Devices**
In accordance with Rhode Island General Law §27-20-43, this *agreement* provides coverage for FDA approved contraceptive drugs requiring a prescription and devices requiring a prescription. The following list is based on the most current FDA approved contraceptive drugs and devices requiring a prescription and is subject to change:
- surgical insertion, removal and removal with reinsertion of contraceptive implants. Contraceptive implants are included in our *allowance* for the surgical insertion/reinsertion procedure. See Section 3.37 Surgery Services for how we cover surgical services.
- surgical implantation and removal of intrauterine device (IUD). The IUD is included in our *allowance* for the surgical implantation procedure. See Section 3.37 Surgery Services for how we cover surgical services.
- diaphragms supplied in a *doctor’s* office are covered as a medical supply and subject to the *level of coverage* for medical equipment, medical supplies, and prosthetic devices received as an *outpatient*. See Section 3.23 Medical Equipment, Medical Supplies, and Prosthetic Devices.
- injectable contraceptive prescription drugs supplied and administered by a *doctor* are covered as an injectable prescription drug dispensed and administered by a licensed health care *provider* (other than a pharmacist). See Section 3.29 Prescription Drugs.
- prescribed oral contraceptives, contraceptive patches, diaphragms, and injectable contraceptive prescription drugs purchased at a *network pharmacy* are covered as a prescription drug purchased at a pharmacy. See Section 3.29 Prescription Drugs.

See the Summary of Benefits for *benefit limits* and *level of coverage* for each section.
Related Exclusions
A church or qualified church-controlled organization as defined in 26 USC 3121 may opt to exclude coverage for contraceptive drugs and devices. See Summary of Benefits to determine coverage of contraceptive drugs and devices, if any.

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

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

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

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

Some diabetic equipment and supplies can be bought at a network pharmacy. When bought at a network pharmacy, the covered diabetic equipment and supplies are subject to the benefit limits and level of coverage shown in the Summary of Pharmacy Benefits. See Section 3.29 - Prescription Drugs.

In addition, to the benefit limits and level of coverage shown in the Summary of Benefits, we cover office visits to a podiatrist and to an optometrist or ophthalmologist for members with diabetes. We cover other office visits. For office visits to a podiatrist, see Section 3.27 - Podiatrist Services. For vision care, see Section 3.38 – Vision Care Services.

3.8 Diagnostic Imaging, Lab, and Machine Tests
Inpatient/Outpatient/In a Doctor's Office
If a doctor orders the following tests to diagnose or treat a condition resulting from illness or injury, we cover the following services:

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

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

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

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

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

If a diagnostic imaging, lab or machine test service is rendered and a surgical procedure is performed at the same time, the level of coverage for each service is based on the type of service being rendered. For surgical services (including but not limited to biopsies, lesion removals, or endoscopies) see Section 3.37 Surgery Services. For diagnostic imaging, labs, or machine tests see Section 3.8 - Diagnostic Imaging, Lab and Machine Tests.

For Preventive Care Services and Early Detection Services, see Section 3.30.

Related Exclusions
This agreement does NOT cover the following:
• re-reading of diagnostic tests by a second doctor;
• dental X-rays (except when ordered by a doctor/dentist to diagnose a condition due to an accident to your sound natural teeth. See Section 3.11 - Emergency Room Services for details);
• bone marrow blood supply MRI;
• genetic testing for screening purposes;
• audiometric hearing or speech services if another entity or agency is responsible for such services under state or federal laws which provide service for the health of school children or children with disabilities. (See generally, Title 16, Chapters 21, 24, 25, and 26 of the Rhode Island General Laws. See also regulations about the health of school children and the special education of children with disabilities or similar rules set forth by federal law or state law of applicable jurisdiction.);
• over the counter diagnostic devices or kits even if prescribed by a physician, except for those devices or kits related to the treatment of diabetes;
• home sleep studies, unless administered and attended by a sleep technologist; or
• nicotine lab tests.
3.9 Doctors' Hospital Visits

For coverage of surgeons, see Section 3.37 - Surgery Services.

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

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

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

3.10 Early Intervention Services (EIS)

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

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

See the Summary of Medical Benefits for the maximum benefit limit and level of coverage.

Related Exclusions

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

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

3.11 Emergency Room Services

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

If you have an accident or medical emergency that needs emergency room services and your first visit to the emergency room occurs within twenty-four (24) hours of the accident or onset of symptoms, we cover the hospital emergency room services and the doctor's services.
Bandages, crutches, canes, collars, and other supplies incidental to your treatment in the emergency room are covered as part of our allowance for the emergency room services.

When physician services are rendered in the emergency room, other than the emergency room physician examination, the level of coverage is based on the type of service being rendered. For surgery services (including but not limited to sutures, fracture care, and other surgical procedures), see Section 3.37 - Surgery Services. For a specialist exam, see Section 3.24 - Office Visits. For diagnostic imaging, lab and machine tests, see Section 3.8. See the Summary of Benefits for benefit limits and level of coverage for each type of service.

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

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

If you receive these services in a doctor/dentist’s office, you are responsible for any applicable office visit copayment. See Section 3.24 - Office Visits.

Medically necessary services are covered when received within seventy-two (72) hours of an accidental injury to your sound natural teeth. The following services are covered:
- Extraction of teeth needed to avoid infection of teeth damaged in the injury;
- Suturing;
- Reimplanting and stabilization of dislodged teeth;
- Repositioning and stabilization of partly dislodged teeth; and
- Dental x-rays.

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

**Related Exclusions**
This agreement does NOT cover:
- hospital or other facility’s services for treatment received in an emergency room for a non-emergency condition;
- follow-up visits to the emergency room;
- dental injuries incurred as a result of biting or chewing; or
- any dental services other than those specifically listed above for injury to your teeth.

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

**Related Exclusions**

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

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

- Final approval for the use of a specific service for a specific condition from the appropriate governmental regulatory body; OR
- Demonstrated, reliable evidence based upon an entry in at least one of the three standard reference compendia (shown in subsection 4 (c) of this Section 3.12); OR
- Sound scientific studies published in authoritative, peer reviewed medical journals that:
  - show statistically significant outcomes about the effectiveness of the service, and
  - permit a consensus of opinion that the service improves the member’s net health outcome, and
  - show it is as beneficial as any established alternatives, and
  - show that the improvement is attainable outside the *investigational* setting; OR
- The determination by an expert medical consultant retained by us, for the purpose of reviewing a particular service, that the service is not *experimental/investigational* for that particular member’s case.

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

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

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

3.13 Hemodialysis Services

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

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

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

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

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

3.14 Hemophilia Services

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

For information about coverage for prescription drugs, including, but not limited to clotting factor drugs, see Section 3.29 - Prescription Drugs.

### 3.15 Home Health Care

#### In Your Home

If you qualify to receive health care at home, we cover home health care services provided by a hospital’s home health care agency or community home health care agency.

We cover the following *medically necessary* services:

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

For information about *doctor* home and office visits see Section 3.18 - House Calls and Section 3.24 - Office Visits. For home care equipment and supplies, see Section 3.23 - Medical Equipment, Medical Supplies, and Prosthetic Devices. For radiation therapy or chemotherapy services, see Section 3.32 - Radiation Therapy/Chemotherapy Services. For prescription drugs, see Section 3.29 - Prescription Drugs.

**Related Exclusions**

This *agreement* does NOT cover:

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

### 3.16 Hospice Care

#### Inpatient

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

**Related Exclusions**

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

#### In Your Home

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

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

For information about doctor home and office visits, see Section 3.18 - House Calls and Section 3.24 - Office Visits. For hospice care equipment and supplies, see Section 3.23 - Medical Equipment, Medical Supplies, and Prosthetic Devices. For prescription drugs, see Section 3.29 - Prescription Drugs.

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

### 3.17 Hospital Services

#### Inpatient

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

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

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

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

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

Hospital services and free-standing ambulatory surgi-center services provided in connection with a dental service are covered when:
• the use of the hospital or free-standing ambulatory surgi-center is medically necessary; and
• the setting in which the service received is determined to be appropriate.

Preauthorization is recommended for this service.

#### Related Exclusions

This agreement does NOT cover:
• extra charges for a private room;
• the dental services that are performed with covered hospital services or with covered free-standing ambulatory surgi-center services (see Section 4.17 for a list of excluded dental services).

### 3.18 House Calls

We cover doctor visits in your home if you have a condition due to an injury or illness which:
• confines you to your home;
• requires special transportation; or
• requires the help of another person.
3.19 Human Leukocyte Antigen Testing
In accordance with Rhode Island General Law §27-20-36, we cover human leukocyte antigen testing for A, B, and DR antigens once per member per lifetime for utilization in bone marrow transplantation. The testing must be performed in a facility which is:
• accredited by the American Association of Blood Banks or its successors; and
• licensed under the Clinical Laboratory Improvement Act as it may be amended from time to time.

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

3.20 Infertility Services
Inpatient/Outpatient/In a Doctor’s Office
In accordance with Rhode Island General Law §27-20-20, this agreement provides coverage for medically necessary services for the diagnosis and treatment of infertility for women. We cover donor gametes if provided through a program. We only cover these services if you are:
• married; (according to the statutes of the state in which you were married); and
• unable to conceive or sustain a pregnancy during a one (1) year period; AND
• a presumably healthy individual.

Infertility services, including prescription drug coverage, are covered up to the benefit limit and level of coverage shown in the Summary of Benefits. Infertility prescription drug coverage is based on the route of administration and site of service. See Section 3.29 - Prescription Drugs for details. See the Summary of Pharmacy Benefits for benefit limits and level of coverage.

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

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

Outpatient
If you receive infusion therapy services in a hospital’s outpatient unit, we cover the use of the treatment room, related supplies, and solutions. For prescription drug coverage, see Section 3.29 - Prescription Drugs.

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

In a Doctor’s Office
If you receive infusion therapy services in a doctor’s office, we cover the related supplies and solutions. For prescription drug coverage, see Section 3.29 - Prescription drugs.
In Your Home

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

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

For information about doctor home and office visits see Section 3.18 - House Calls and Section 3.24 - Office Visits. For home care equipment and supplies, see Section 3.23 - Medical Equipment, Medical Supplies, and Prosthetic Devices. For radiation therapy or chemotherapy services, see Section 3.32 - Radiation Therapy/Chemotherapy Services. For prescription drugs, see Section 3.29 - Prescription Drugs.

Related Exclusions

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

3.22 Lyme Disease Diagnosis and Treatment

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

For coverage of specific services, see Section 3.8 - Diagnostic Imaging, Lab, and Machine Tests, 3.24 - Office Visits, 3.21 Infusion Therapy, and 3.29 - Prescription Drugs.

3.23 Medical Equipment, Medical Supplies, Enteral Formula or Food, and Prosthetic Devices

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

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

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

MEDICAL SUPPLIES means those consumable supplies which are disposable and not intended for re-use. Medical supplies require an order by a physician and are essential for the care or treatment of an illness, injury, or congenital defect.
PROSTHETIC DEVICES means devices (other than dental) which replace or substitute all or a part of an internal body part (including contiguous tissue), or replace all or part of the function of a permanently inoperative or malfunctioning body part necessary to alleviate functional loss or impairment due to an illness, injury or congenital defect.

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

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

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

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

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

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

Medical Supplies
We will cover the following medical supplies subject to our guidelines:
- Essential accessories such as hoses, tubes and mouthpieces for use with medically necessary durable medical equipment (these accessories are included as part of the rental allowance for rented equipment);
- Catheters, colostomy and ileostomy supplies, irrigation trays and surgical dressings;
- Diaphragms supplied in a doctor’s office; and
- Respiratory therapy equipment solutions.

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

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

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

This agreement provides benefits for mastectomy-related prosthetics in accordance with the Women’s Health and Cancer Rights Act of 1998 and Rhode Island General Laws 27-20-29 et seq. See Section 3.37 Surgery Services - Mastectomy.

Related Exclusions

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

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

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

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

This agreement does NOT cover pillows or batteries, except when used for the operation of a covered prosthetic device, or items whose sole function is to improve the quality of life or mental well being. See Section 4.28 for a list of personal appearance and service items NOT covered by this agreement.

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

Enteral formulas or food (enteral nutrition)

Enteral formula or food is nutrition that is absorbed through the intestinal tract, whether delivered through a tube for feeding or taken orally. The level of coverage differs depending on whether the enteral formula or food is the sole source of nutrition delivered through a feeding tube or taken orally.
This agreement provides coverage for enteral formula and supplies to administer enteral formula when it is delivered through a feeding tube and is the sole source of nutrition. See the Summary of Medical Benefits for level of coverage.

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

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

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

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

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

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

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

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

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

### 3.24 Office Visits

**In a Doctor’s Office**

Our allowance for an office visit includes medical supplies provided as part of the office visit. See the Summary of Medical Benefits for benefit limits and level of coverage for each service in this section.

When physician services are rendered in a doctor’s office, other than an office visit examination, the level of coverage is based on the type of service being rendered. For surgical services (including but not limited to sutures, fracture care, and other surgical procedures) see Section 3.37 Surgery Services. For diagnostic imaging, lab and machine tests, see Section 3.8.

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

**Asthma Education**

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

Other asthma related covered health care services including, but not limited to, office visits rendered by a provider (other than a certified asthma educator), medical equipment and supplies, and prescription drugs are subject to the benefit rules that apply to the specific services. For information about office visits, see Section 3.24 - Office Visits. For medical equipment and supplies, see Section 3.23 - Medical Equipment, Medical Supplies, and Prosthetic Devices. For prescription drugs, see Section 3.29 - Prescription Drugs. See the Summary of Benefits for benefit limits and level of coverage for each section.

**Diabetes Education**

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

**Hospital Based Clinic Visits**

Other covered health care services provided by a clinic, such as physical therapy or occupational therapy, are subject to the benefit rules that apply to the specific service.
Nutritional Counseling
Nutritional counseling is covered. It must be prescribed by a physician and performed by a registered dietitian/nutritionist. Nutritional counseling visits may be covered for healthy individuals seeking nutritional information, desiring weight loss, or for the purpose of treating an illness.

Office Visits (other than Pediatric Office Visits)
We cover other medically necessary office visits, including visits to urgent care centers, provided they are reasonable in number and in the scope of the services rendered for the following:
- office visits to personal physician;
- office visits to specialists;
- routine examinations;
- consultations;
- medication visits for outpatient mental illness; or
- office visits to oral and maxillofacial surgeons (OMS) for medical conditions.

See the Summary of Medical Benefits for benefit limits and level of coverage. For prescription drug coverage, see Section 3.29 - Prescription Drugs. For doctor visits to your home, see Section 3.18 - House Calls.

Obstetrical or Gynecological Care
You do not need preauthorization from us or from any other person (including a personal physician) in order to obtain access to obstetrical or gynecological care from a network doctor who specializes in obstetrics or gynecology. Your doctor, however, may be required to comply with certain procedures, including obtaining preauthorization for certain services. For a list of network physicians who specialize in obstetrics or gynecology, contact our Customer Service Department.

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

Allogenic bone marrow transplant covered health care services include medical and surgical services for the matching participant donor and the recipient. However, Human Leukocyte Antigen testing is covered as indicated in the Summary of Benefits, subject to certain conditions. For details see Section 3.19 - Human Leukocyte Antigen Testing.

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

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

The national transplant network program is called the Blue Distinction Centers for TransplantsSM. For more information about the Blue Distinction Centers for TransplantsSM 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 level of coverage for transplant services for the recipient and eligible donor is based on the type of service. For information about office visits see Section 3.24 - Office Visits. For surgical procedures see Section 3.37 - Surgery Services. For lab, radiology, and machine tests see Section 3.8 - Diagnostic Imaging, Lab, and Machine Tests. For prescription drugs, see Section 3.29 - Prescription Drugs. See the Summary of Benefits for benefit limits and level of coverage for each type of service.

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

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

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

**Outpatient/In a Doctor's/Therapist's Office**
Physical or occupational therapy services received in a doctor's/therapist's office are covered. See the Summary of Benefits for benefit limits and level of coverage.

**In Your Home**
This agreement does NOT cover physical or occupational therapy services received in your home unless received through a home care program. See Section 3.15 - Home Health Care.
Related Exclusions
This agreement does NOT cover:
• services rendered by a massage therapist.
• hippotherapy.

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

3.27 Podiatrist Services
This agreement covers office visits to the podiatrist.

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

This agreement does NOT cover the treatment of flat feet unless the treatment is surgical. Corrective or orthopedic shoes and orthotic devices used in connection with footwear are NOT covered unless for the treatment of diabetes. See Section 3.7 - Diabetic Equipment/Supplies.

3.28 Pregnancy Services and Nursery Care
Statement of Rights Under the Newborns’ and Mothers’ Health Protection Act
Under federal law, 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). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain preauthorization. For information on preauthorization, contact our Customer Service Department at (401) 459-5000 or 1-800-639-2227.

Inpatient
In accordance with Rhode Island General Law §27-20-17.1, this agreement covers a minimum inpatient hospital stay of forty-eight (48) hours from the time of a vaginal delivery and ninety-six (96) hours from the time of a cesarean delivery.
• If the delivery occurs in a hospital, the hospital length of stay for the mother or newborn child begins at the time of delivery (or in the case of multiple births, at the time of the last delivery).
• If the delivery occurs outside a hospital, the hospital length of stay begins at the time the mother or newborn is admitted as a hospital inpatient in connection with childbirth.

Any decision to shorten these stays shall be made by the attending physician in consultation with and upon agreement with you. In those instances where you and your infant participate in an early discharge, you will be eligible for:
• Up to two (2) home care visits by a skilled, specially trained registered nurse for you and/or your infant, (any additional visits must be reviewed for medical necessity); and
• A pediatric office visit within twenty-four (24) hours after discharge.

See Section 3.18 - House Calls and Section 3.24 - Office Visits for coverage of home and office visits.

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

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

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

The first office visit to diagnose pregnancy is not included in prenatal services. Office visits to an obstetrician or midwife that are not related to pregnancy are not included in prenatal services. Both are covered as an office visit. See Section 3.24 - Office Visits.

3.29 Prescription Drugs and Diabetic Equipment/Supplies
Definitions
The following definitions apply to this Section 3.29:

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

Quantity limits may apply. Some prescription drugs are subject to additional quantity limits based on criteria that we have developed. You may obtain a current list of prescription drugs that have been assigned maximum quantity levels for dispensing by visiting our Web site at 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 section **A. Pharmacy Program for Prescription Drugs and Diabetic Equipment/Supplies Purchased at a Pharmacy** listed below. Services for which prescription drug preauthorization is required are marked with a (+) symbol in the Summary of Pharmacy Benefits.
**SITE OF SERVICE** means, for the purposes of this *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* and diabetic equipment and supplies that are bought at a pharmacy. The prescription drug must be identified as covered under this *agreement* in our *formulary* and dispensed per our *dispensing guidelines* in order to be covered.
Generic, preferred brand name, and non-preferred brand name prescription drugs may be dispensed at a retail pharmacy, a specialty pharmacy, a mail order pharmacy, or by a provider other than a pharmacy. Specialty prescription drugs must be dispensed at a specialty pharmacy or a non-network pharmacy. If a professional provider dispenses a specialty prescription drug, it is not separately reimbursed unless obtained from a specialty pharmacy. The administration of the specialty prescription drug is covered.

For information about the administration of specialty prescription drugs, see Section 3.2 - Behavioral Health, Section 3.14 - Hemophilia Services, Section 3.15 - Home Health Care, Section 3.20 - Infertility Services, Section 3.21 - Infusion Therapy, Section 3.24 - Office Visits, and Section 3.32 - Chemotherapy Services.

If you are dispensed a specialty prescription drug from a Rhode Island network provider, the charge for the specialty prescription drug is not reimbursed and the Rhode Island network provider may not seek reimbursement from you. If you are dispensed a specialty prescription drug from a non-network provider 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 level of coverage.

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

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

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

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

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

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

Our formulary lists generic, preferred brand name, and non-preferred brand name prescription drugs and specialty prescription drugs covered under this agreement. We decide which tier a drug will be placed into for copayment purposes. To check the tier placement of a prescription drug or to obtain a copy of the most current formulary listing, visit our Web site at 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 level of coverage shown in the Summary of Pharmacy Benefits. For mail order instructions, please call our Customer Service Department.

Covered Diabetic Equipment/Supplies
The following diabetic equipment and supplies can be bought at a network pharmacy:
• Glucometers;
• Test Strips;
• Lancet and Lancet Devices; and
• Miscellaneous Supplies (including and calibration fluid).

See the Summary of Pharmacy Benefits for benefit limits and level of coverage.

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

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

If you buy 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 certain specialty prescription drugs. To obtain prescription drug preauthorization, the prescribing provider must submit a completed prescription drug preauthorization request form.

The prescribing provider may obtain a prescription drug preauthorization form by visiting our website at BCBSRI.com or calling the Physician and Provider Service Center. Preauthorization requests may be submitted in one of the following ways:
• By fax, submit the form to CVS Caremark at 1-888-836-0730;
• By phone, contact CVS Caremark at 1-800-294-5979;
• By mail, send the completed form to:
Prescription drugs that require prescription drug preauthorization will only be approved when our clinical guidelines are met. The guidelines are based upon clinically appropriate criteria that ensure that the prescription drug is appropriate and cost-effective for the illness, injury or condition for which it has been prescribed.

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

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

If you have not obtained prescription drug preauthorization before you pick up the prescription drug from the pharmacy for the first time, you can ask us to consider reimbursement later. To do this, you must follow the prescription drug preauthorization process described above and submit your request for review, along with a copy of your receipt, within fifteen (15) days of picking up the prescription. If our clinical guidelines are met for the prescription drug, we will approve your claim to be reimbursed retroactively less the applicable copayment or deductible.

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

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

**How to Obtain Dose Optimization**

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

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

If your prescribing provider deems it medically necessary that you continue to take multiple daily doses of a lower strength generic, preferred brand name, or non-preferred brand name
prescription drug, \textit{prescription drug preauthorization} is required and must be obtained before we provide coverage. To request \textit{prescription drug preauthorization}, the prescribing \textit{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 \textit{provider} may obtain a form by visiting our Web site at BCBSRI.com or calling the Physician and Provider Service Center. Requests may be submitted in one of the following ways:

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

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

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

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

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

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

\textbf{Co-payment reduction}
Certain prescription drugs will have a reduced \textit{copayment} for members with diabetes, asthma, and chronic obstructive pulmonary disease (COPD). To obtain a specific list of the included drugs, call our Customer Service Department or visit our website at \url{www.bcbsri.com}. 
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;
• experimental prescription drugs (including those placed on notice of opportunity hearing status by the Federal Drug Efficacy Study Implementation (DESI));
• drugs you take or have given to you while you are a patient in a hospital, rest home, sanitarium, nursing home, home care program, or other institution that provides prescription drugs as part of its services or which operates its own facility for dispensing prescription drugs;
• non-medical substances (regardless of the reason prescribed, the intended use, or medical necessity);
• off-label use of prescription drugs (except as described in Section 3.12 Experimental/Investigational Services);
• over-the-counter (OTC) drugs even if prescribed, unless specifically listed as a covered health care service in this agreement (e.g., such as OTC nicotine replacement therapy in accordance with Rhode Island General Law 27-20-53 and PPACA or as part of our OTC Options Program;
• prescribed weight-loss drugs;
• OTC drugs designated as covered under this agreement for which you do not have a written prescription from your physician
• replacement prescription drug products resulting from a lost, stolen, broken or destroyed prescription order or refill;
• support garments and other durable medical equipment;
• therapeutic devices and appliances, including hypodermic needles and syringes (except when used to administer insulin);
• sildenafil citrate (Viagra) or any therapeutic equivalents; OR
• Vitamins, unless specifically listed as a covered health care service in this agreement.

We will NOT cover a prescription drug refill if the refill is:
• greater than the refill number authorized by your doctor;
• greater than the twelve (12) refills we authorize;
• limited by law; or
• re-filled more than a year from the date of the original prescription.
The following are NOT covered when purchased from a non-network pharmacy:
- generic, preferred brand name, or non-preferred brand name prescription drugs; and
- diabetic equipment and supplies.

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

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

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

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

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

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

Outpatient/In Your Doctor’s Office/In Your Home
Generic, preferred brand name, or non-preferred brand name prescription drugs are covered at different benefit levels depending upon the route of administration. Our allowance for services rendered by the facilities, agencies, and professional providers may include the cost of the prescription drugs administered and/or dispensed. We will determine coverage based upon the route of administration that is customary and least invasive method to treat the condition. There are several ways to administer drugs into the body including:
- inhalation (into the lungs, usually through the mouth);
- intramuscular (injected into a muscle);
- intrathecal (injected into the space around the spinal cord);
- intravenous/infused/intra-arterial (into a vein or artery);
- nasal (sprayed into the nose);
- ocular (instilled in the eye);
- oral (by mouth);
- rectal or vaginal (inserted into the rectum or vagina);
- subcutaneous (injected beneath the skin);
- sublingual (under the tongue);
• topical (applied to the skin); OR
• transdermal (delivered through the skin by a patch).

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

**Injected Generic, Preferred Brand Name, or Non-Preferred Brand Name Prescription Drugs**
We use the term injected to include prescription drugs approved by us given by intra muscular or subcutaneous injection or in the case of a body cavity by instillation. See the Summary of Medical Benefits for *benefit limits* and *level of coverage*. See Section 3.30 Prevention and Early Detection Services for immunization and vaccination coverage information.

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

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

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

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

**3.30 Preventive Care Services and Early Detection Services**
In accordance with PPACA, this *agreement* provides coverage rendered to a *subscriber* for early detection services, preventive *care services*, and immunizations/vaccinations as set forth in the guidelines of the following resources:
• services that have an A or B rating in the current recommendations of the U.S. Preventative Services Task Force (USPSTF);
• immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
• preventive care and screenings for infants, children, and adolescents as outlined in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
• preventive care and screenings for women as outlined in the comprehensive guidelines as supported by HRSA.
Covered early detection services, preventive care services, and adult and pediatric immunizations/vaccination are based on the most currently available guidelines and are subject to change.

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

One pap smear annually is covered at the level of coverage for early detection services as shown in the Summary of Benefits. The level of coverage for your second and subsequent pap smear is covered as a lab test. For information about lab, radiology, and machine tests see Section 3.8 - Diagnostic Imaging, Lab, and Machine Tests.

**Vaccinations/Immunizations**

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

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

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

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

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

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

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

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

In Your Home
We cover private duty nursing services received in your home when medically necessary, ordered by a physician, and performed by a certified home health care agency. Private duty nursing services are covered when the patient requires continuous skilled nursing observation and intervention.

Related Exclusions
This agreement does NOT cover:
- services of a nurse's aide;
- services of a private duty nurse when the primary duties are limited to bathing, feeding, exercising, homemaking, giving oral medications or acting as companion or sitter;
- services of a private duty nurse who is a member of your household or the cost of any care provided by one of your relatives (by blood, marriage or adoption);
- maintenance care when the condition has stabilized (including routine ostomy care or tube feeding administration) or if the anticipated need is indefinite;
- care for a person without an available caregiver in the home (twenty four (24) hour private duty nursing is not covered);
- respite care (e.g., care during a caregiver vacation) or private duty nursing so that the caregiver may attend work or school;
- services of a private duty nurse after the caregiver or patient have demonstrated the ability to carry out the plan of care;
- services of a private duty nurse provided outside the home (e.g., school, nursing facility or assisted living facility);
- services of a private duty nurse that are duplication or overlap of services (e.g., when a person is receiving hospice care services or for the same hours of a skilled nursing home care visit.); or
- services of a private duty nurse that are for observation only.

3.32 Radiation Therapy/Chemotherapy Services

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

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

Outpatient/In a Doctor's Office

Radiation Therapy
We cover hospital and doctor services for outpatient radiation therapy. Radiation physics, dosimetry services, treatment devices, and hospital services are included in radiation treatment planning and therapy and are covered as part of our allowance for radiation therapy.
Chemotherapy Services
This agreement covers the doctor’s administration fee and associated hospital supplies. For information about anti-neoplastic (chemotherapy) prescription drug coverage, see Section 3.29 - Prescription Drugs.

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

Chemotherapy Services
This agreement covers the doctor’s administration fee. For information about anti-neoplastic (chemotherapy) prescription drug coverage, see Section 3.29 - Prescription Drugs.

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

Outpatient/In a Doctor’s Office
We cover outpatient respiratory therapy or respiratory therapy received in a doctor’s office when your doctor orders the therapy under the following conditions:
• as part of a therapeutic program for up to fourteen (14) days before admitting you to the hospital; OR
• up to six (6) weeks after you have been discharged from the hospital.

In Your Home
We cover durable medical equipment and oxygen at the same benefit limit and level of coverage as stated in the Summary of Medical Benefits for medical equipment and medical supplies. See Section 3.23 - Medical Equipment, Medical Supplies, and Prosthetic Devices for details.

Related Exclusions
This agreement does NOT cover respiratory therapy services when received in your home, unless received through a home care program or hospice care program. See Section 3.15 - Home Health Care and Section 3.16 - Hospice Care.

3.34 Skilled Care in a Nursing Facility
Care in a skilled nursing facility is covered if:
• your condition needs skilled nursing services, skilled rehabilitation services or skilled nursing observation;
• the services are required on a daily basis; AND
• this care can be provided ONLY in a skilled nursing facility.

Related Exclusions
This agreement does NOT cover custodial care, respite care, day care, or care in a facility that is not approved by us. See Section 4.6 - Services Provided by Facilities We Have Not Approved.
3.35 Smoking Cessation Programs
In accordance with Rhode Island General Law §27-20-53, this agreement provides coverage for smoking cessation programs. Smoking cessation programs include, but are not limited to, the following:
- Smoking cessation counseling, such counseling must be provided by a physician or upon his or her referral by a qualified licensed practitioner.
- Over-the-counter or FDA approved nicotine replacement therapy and/or smoking cessation prescription drugs when medically necessary, prescribed by a physician, and purchased at a pharmacy.

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

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

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

Outpatient/In a Doctor's/Therapist’s Office
We will cover speech therapy rehabilitative services when received from a registered therapist as part of a formal treatment plan for:
- speech or communication function loss;
- impairment as a result of an acute illness or injury; or
- an acute exacerbation of chronic disease.

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

Some services rendered by a speech therapist are classified as diagnostic tests. See Section 3.8 - Diagnostic Imaging, Lab, and Machine Tests and the Summary of Medical Benefits for benefit limits and level of coverage.

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

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

This agreement does not cover:

- maintenance services;
- educational classes and services for impairments that are self-correcting; or
- services related to food aversion or texture disorders.

This agreement does not cover language and communication developmental services including, but not limited to, the following:

- psychosocial speech delay;
- expressive language delay;
- behavioral problems;
- attention disorders;
- conceptual handicap;
- mental retardation;
- autism;
- developmental delay; or
- stammering and stuttering.

### 3.37 Surgery Services

**General Surgery**

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

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

**In a Doctor's Office**

This plan covers surgical procedures performed in a doctor's office up to the level of coverage indicated in the Summary of Benefits.

When other physician services are rendered in the doctor's office, other than the surgical procedure, the level of coverage is based on the type of service being rendered. For office visits see Section 3.24 Office Visits. For Diagnostic Imaging, Lab, and Machine tests see Section 3.8. See the Summary of Benefits for benefit limits and level of coverage for each section.

**Multiple Surgeries**

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

**If More Than One Surgeon Operates**

In addition to the type and purpose of surgery, our allowance differs depending on the number of surgeons involved, including assistant surgeons.
If two (2) surgeons perform separate operations during a single surgical session, each surgeon may submit a *claim* reporting the procedure performed and the circumstances involved. These *claims* will then be evaluated for payment on an individual basis.

**Related Exclusions**

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

**Mastectomy Services**

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

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

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

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

**Related Exclusions**

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

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

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

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

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

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

- Abdominoplasty;
- Cervicoplasty;
- Chemical exfoliations, peels, abrasions (or dermabrasions or planing for acne, scarring, wrinkling, sun damage or other benign conditions);
- Correction of variations in normal anatomy including augmentation mammoplasty, mastopexy, and correction of congenital breast asymmetry;
- Dermabrasion;
- Ear Piercing or repair of a torn earlobe;
- Excision of Excess Skin or Subcutaneous Tissue (except Panniculectomy as listed above);
- Genioplasty;
- Gynecomastia surgery, including but not limited to mastectomy and reduction mammoplasty;
- Hair Transplants;
- Hair Removal (including electrolysis epilation);
- Inverted nipple surgery;
- Laser treatment for acne and acne scars;
- Osteoplasty - Facial Bone Reduction;
- Otoplasty;
- Procedures to correct visual acuity including, but not limited to, cornea surgery or lens implants;
- Removal of Asymptomatic Benign Skin Lesions;
• Repeated cauterizations or electrofulguration methods used to remove growths on the skin;
• Rhinoplasty;
• Rhytidectomy;
• Scar Revision, regardless of symptoms;
• Sclerotherapy for Spider Veins;
• Subcutaneous Injection of Filling Material;
• Suction assisted Lipectomy;
• Tattooing or Tattoo Removal (except tattooing of the nipple/areola related to a mastectomy); or
• Testicular prosthesis surgery.

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

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

Our allowance for the surgical procedure includes local anesthesia.

Other than the pre-operative office visit, this agreement covers office visits or office consultations to anesthesiologists as an office visit. See Section 3.24 - Office Visits.

Anesthesia services when rendered at a hospital or free-standing ambulatory surgi-center in connection with a dental service are covered when the use of the hospital or free-standing ambulatory surgi-center is medically necessary and the setting in which the service received is determined to be appropriate. Preauthorization is recommended for this service. The dental services will remain non-covered. See Section 4.18.

Related Exclusions
This agreement does NOT cover:
• local anesthesia provided by an anesthesiologist or anesthesia administered by a surgeon, assistant surgeon, or obstetrician;
• services of a standby anesthesiologist; and
• patient controlled analgesia, also known as pain management.

3.38 Vision Care Services
Eye Examinations
We cover one routine eye exam per contract year if an optometrist or ophthalmologist performs the examination. We cover medically necessary eye examinations.
4.0 HEALTH CARE SERVICES NOT COVERED UNDER THIS AGREEMENT

This agreement does NOT cover health care services which:

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

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

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

If a service or category of service is not listed as covered, it is not covered under this agreement.

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

4.1 Services Not Medically Necessary

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

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

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

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

4.2 Services Not Listed in Section 3.0

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

4.3 Services Covered by the Government

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

4.4 Services and Supplies Mandated by Laws in Other States
Any charges for services and supplies which are required under the laws of a state other than the Rhode Island law and which are not provided under this agreement are NOT covered.

4.5 Services Provided By College/School Health Facilities
This agreement does NOT cover health care services received in a facility mainly meant to care for students, faculty, or employees of a college or other institution of learning.

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

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

4.8 Services Performed by People/Facilities Who Are Not Legally Qualified or Licensed
This agreement does NOT cover health care services performed in a facility or by a physician, surgeon, or other person who is not legally qualified or licensed, according to relevant sections of Rhode Island Law or other governing bodies, or who does not meet our credentialing requirements.

4.9 Services Performed by Naturopaths and Homeopaths
This agreement does NOT cover health care services ordered or performed by naturopaths and homeopaths.

4.10 Services If You Leave the Hospital or If You Are Discharged Late
If you leave the hospital for a day or portion of a day, this agreement does NOT cover any hospital services for that day (unless you leave to receive treatment somewhere else or through a 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 health care services provided to you when there is no charge to you or there would have been no charge to you absent this

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Health Care Services Not Covered Under This Agreement

EXCLUSIONS GRP (09/10)
**agreement.** This *agreement* does NOT cover health care services when you can recover all or a portion of the cost of such services through a federal, state, county, or municipal law or through legal action. This is true even if you choose not to assert your rights under these laws or if you fail to assert your rights under these laws.

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

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

**4.13 Charges for Administrative Services**
This *agreement* does NOT cover:
- charges for missed appointments;
- charges for completion of claim forms; or
- other administrative charges.

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

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

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

**4.17 Deductibles and Copayments**
This *agreement* does NOT cover deductibles or copayments, if any.

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

This *agreement* does NOT cover any preparation of the mouth for dentures and dental or oral  
surgeries such as, but not limited to:  
• apicoectomy, per tooth, first root;  
• alveolecctomy including curettage of osteitis or sequestrectomy;  
• alveoloplasty, each quadrant;  
• complete surgical removal of inaccessible impacted mandibular tooth mesial surface;  
• excision of feberous tuberosities;  
• excision of hyperplastic alveolar mucosa, each quadrant;  
• operculectomy excision periocoronal tissues;  
• removal of partially bony impacted tooth;  
• removal of completely bony impacted tooth, with or without unusual surgical  
  complications;  
• surgical removal of partial bony impaction;  
• surgical removal of impacted maxillary tooth;  
• surgical removal of residual tooth roots; or  
• vestibuloplasty with skin/mucosal graft and lowering the floor of the mouth.

4.19 **Employment–Related Injuries**  
This *agreement* does NOT cover health care services when performed to treat work-related  
illnesses, conditions, or injuries whether or not you are covered by Workers’ Compensation  
law, unless:  
• you are self-employed, a sole stockholder of a corporation, or a member of a  
  partnership;  
• such work-related illnesses, conditions, or injuries were incurred in the course of your  
  self-employment, sole stockholder, or partnership activities; AND  
• you are not enrolled as an employee under a 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 and contact lenses are NOT covered unless specifically listed as a covered health care service in this agreement.

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

4.23 **Freezing and Storage of Blood, Sperm, Gametes, Embryo and Other Specimens**
This agreement does NOT cover freezing and storage of blood, gametes, sperm, embryos, or other tissues for future use. This agreement does NOT cover any services for drawing, processing, or storage of your own blood.

4.24 **Gene Therapy, Genetic Screening, and Parentage Testing**
This agreement does NOT cover gene therapy, genetic screening, or parentage testing.

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

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

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

4.28 **Personal Appearance and/or Service Items**
Services and supplies for your personal appearance and comfort, whether or not prescribed by a doctor and regardless of your condition, are NOT covered. These services and supplies include, but are not limited to:
- radio,
- telephone,
- television,
- air conditioner,
- humidifier,
- air purifier, or
- beauty and barber services.

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

This agreement does NOT cover items that do not meet the durable medical equipment, medical supplies, and prosthetic devices minimum specifications. These items include, but are not limited to:
• standers,
• raised toilet seats,
• toilet seat systems,
• cribs,
• ramps,
• positioning wedges,
• wall or ceiling mounted lift systems,
• water circulating cold pads (cryo-cuffs),
• car seats (including any vest system) or car beds,
• bath or shower chair systems,
• trampolines,
• tricycles,
• therapy balls, or
• net swings with a positioning seat.

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

4.30  **Research Studies**
This *agreement* does NOT cover research studies.

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

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

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

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

4.35  **Surrogate Parenting**
This *agreement* does NOT cover any services related to surrogate parenting. This *agreement* does NOT cover the newborn child of a surrogate parent.
4.36 Therapies, Acupuncture and Acupuncturist Services, and Biofeedback

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

This agreement does NOT cover acupuncture and acupuncturist services, including X-ray and laboratory services ordered by an acupuncturist, unless otherwise specified in this agreement.

This agreement does NOT cover:
- pelvic floor electrical stimulation,
- pelvic floor magnetic stimulation,
- pelvic floor exercise,
- biofeedback training,
- biofeedback by any modality for any condition, and
- any other exercise therapy.

4.37 Weight Loss Programs

This agreement does NOT cover health care services, including drugs, related to programs designed for the purpose of weight loss. These health care services include, but are not limited to, commercial diet plans, weight loss programs, and any services in connection with such plans or programs.
5.0 HOW YOUR COVERED HEALTH CARE SERVICES ARE PAID
Payments we make to you are personal and you cannot transfer or assign any of your right to receive payments under this agreement to another person or organization.

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

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

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

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

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

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

Out-of-Area Services

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

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

BlueCard® Program

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

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

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

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

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

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

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

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

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

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

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

6.1 Definitions
The following definitions apply to Section 6:

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

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

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

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

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

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

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

6.2 When You Have More Than One Agreement with Blue Cross & Blue Shield of Rhode Island
If you are covered under more than one agreement with us, you are entitled to covered benefits under both agreements. If one agreement has a benefit that the other(s) does not, you are entitled to coverage under the agreement that has the benefit. The total payments you receive will never be more than the total cost for the services you receive.
6.3 When You Are Covered By More Than One Insurer

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

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

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

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

(1.) Non-Dependent/Dependent - If you are covered under a plan and you are the main subscriber, the benefits of that plan will be determined before the benefits of a plan which covers you as a dependent. If, however, you are a Medicare beneficiary, then, in some instances, Medicare will be Secondary and the plan which covers you as the main subscriber or as a dependent will provide the benefits first.

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

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

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

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

If the terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the parent's benefits under that parent's plan has actual knowledge of those terms, the benefits of that plan are determined first and the benefits of the plan of the other parent are the secondary plan.
If the terms of a court decree state that the parents share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in Section 6.3 (2) above.

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

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

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

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

**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 HOW TO FILE AND APPEAL A CLAIM
Our Customer Service Department phone number is (401) 459-5000 or 1-800-639-2227.

7.1 How to File a Claim
You must file all claims within one calendar year of the date you receive a covered health care service. Member submitted claims that arrive after this deadline are invalid unless:
• it was not reasonably possible for you to file your claim prior to the filing deadline; AND
• you file your claim as soon as possible but no later than ninety (90) calendar days after the filing deadline elapses (unless you are legally incapable).

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

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

Non-network providers may or may not file claims for you. If the non-network provider does not file the claim on your behalf, you will need to file the claim yourself. To file a claim, please send us an itemized bill including the following:
• patient's name;
• your member identification number;
• the name, address, and telephone number of the provider who performed the service;
• date and description of the service; AND
• charge for that service.

Please mail the claim to:
Blue Cross & Blue Shield of Rhode Island
Attention: Claims Department
500 Exchange Street
Providence, RI 02903

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

An Administrative Appeal is a verbal or written request for us to reconsider a full or partial denial of payment for services that were denied because:
• the services were excluded from coverage;
• we failed to make payment (in whole or part) for a service;
• we determined that you were not 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 and provide specific instructions for filing a medical appeal.

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

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

- name, address, and member ID number;
- summary of the medical appeal, any previous contact with 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 a medical appeal is being filed on your behalf, you must send us a notice with your signature, authorizing the individual to represent you in this matter.

Written medical appeals should be sent to:

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 levels of review when seeking a medical appeal.

**Level 1 Review**
You may request a Level 1 review of any matter subject to medical appeal by making a request for such review to us within one hundred and eighty (180) calendar days of the initial determination letter. You may ask for this review by calling our Customer Service Department, but we strongly suggest that you submit your request in writing to ensure your request is accurately reflected. At any time during the Level 1 Review (or Level 2 Review, see below), you may supply additional information by mailing it to the address listed above. You may request copies of information relevant to your appeal (free of charge) by contacting our Grievance and Appeal Unit.

For pre-service (before services are rendered) or concurrent (during a patient’s hospital stay or course of treatment) appeals, you will receive written notification of the determination on a Level 1 review within fifteen (15) calendar days of receipt of the appeal request. If you are requesting reconsideration of a service that was denied after you already obtained the service (retrospectively), then you will receive written notification of our determination within fifteen (15) business days of our receipt of the appeal.

**Level 2 Review**
You may request a Level 2 review (preferably in writing) if our denial was upheld during the Level 1 review process. Your Level 2 review will be reviewed by a provider in the same or similar specialty as your treating provider. You must submit your request for a Level 2 review within one hundred and eighty (180) calendar days of receipt of the Level 1 determination letter. Upon request for a Level 2 review, we will provide you with the opportunity to inspect the medical file and add information to the file.

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

**Expeditied (Urgent) Review**
You may ask for an expeditied (urgent) appeal if:
- an urgent preauthorization request for health care services has been denied (See Section 1.6 – Preauthorization for additional information about urgent preauthorization requests);
- the circumstances are an emergency; or
- you are in an inpatient setting.

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

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

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

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

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

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

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

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

7.6 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

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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.

7.4 Grievances Unrelated to Claims

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

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

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

7.6 Our Right to Withhold Payments

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

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

Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**CHEMICAL DEPENDENCY** means the chronic abuse of alcohol or other drugs. It is characterized:
- by impaired functioning;
- debilitating physical condition;
- the inability to keep from or reduce consuming the substance; *OR*
- the need for daily use of the chemical in order to function.
The term "chemical" includes alcohol and addictive drugs. It does not include caffeine or tobacco.

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

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

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

**CONTRACT 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 contract year. A contract year can be either a calendar year or a plan year.

- **Calendar year** means that the coverage is based on a twelve (12) month period beginning on January 1st and ending on December 31st.
- **Plan year** means coverage is based on a period of twelve (12) consecutive months that are not a calendar year (for example, July 1st in one year through June 30th in the following year). A plan year is also the one-year period that begins on the anniversary date of your employer/agent’s group agreement.

For more information about the type of contract year that applies to your coverage, please call our Customer Service Department or contact your employer directly.

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

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

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

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

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

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

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

**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*.

**EXPERIMENTAL/INVESTIGATIONAL** means any health care service that has progressed to
limited human application, but has not been recognized as proven and effective in clinical
medicine. See Section 3.12 for a more detailed description of the type of health care services
we consider experimental/investigational.

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

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

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

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

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

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

**LEVEL OF COVERAGE** means the amount that we pay for a covered health care service. A copayment, deductible, or maximum benefit may be applied. The level of coverage differs depending on whether you are treated by a network or a non-network provider. See the Summary of Benefits for details about your level of coverage.

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

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

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

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

**MAXIMUM OUT-OF-POCKET EXPENSE** means the total amount of copayments that you must pay each contract year for certain covered health care services.

Unless otherwise indicated, we will pay up to 100% of our allowance for the rest of the contract year once you have met the maximum out-of-pocket expense.

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

**MEDICALLY NECESSARY** means that the health care services provided to treat your illness or injury, upon review by Blue Cross & Blue Shield of Rhode Island are:

- appropriate and effective for the diagnosis, treatment, or care of the condition, disease ailment or injury for which it is prescribed or performed;
- appropriate with regard to generally accepted standards of medical practice within the medical community;
- not primarily for the convenience of the member, the member’s family or provider of such member; AND
- the most appropriate supplies or level of service which can safely be provided to the member, i.e. no less expensive professionally acceptable alternative is available.

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

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

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

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

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

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

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

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

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

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

Preauthorization is the approval that we advise you to seek before receiving certain covered health care services. Selected prescription drugs bought at a pharmacy require prescription drug preauthorization. (See Section 3.29 for details.) Preauthorization ensures that services are medically necessary and performed in the most appropriate setting. Network providers are responsible for obtaining preauthorization for all applicable covered health care services.
You are responsible for obtaining preauthorization when the provider is non-network or if the services are rendered by a provider or facility that participates with an out-of-state Blue Cross or Blue Shield plan (BlueCard). If you do not obtain preauthorization and the services are determined to be not medically necessary or the setting in which the services were received is determined to be inappropriate, we will not cover these services/facilities.

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

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

We encourage you to contact us at least two (2) working days before you receive any covered health care service for which preauthorization is recommended.

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

**PREVENTIVE CARE SERVICES** means covered health care services performed to prevent the occurrence of disease. See Section 3.30 - Preventive Care Services and Early Detection Services.

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

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

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

**REHABILITATIVE SERVICES** means acute short-term therapies that can only be provided by a qualified professional. The therapies are used to treat functional deficiencies that are the result of injury or disease. Short-term therapies are services that result in measurable and meaningful functional improvements within sixty (60) days.
The services must be
- consistent with the nature and severity of illness;
- be considered safe and effective for the patient’s condition;
- be used to restore function.

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

See Section 3.36 - Speech Therapy and the Summary of Medical Benefits for benefit limits and level of coverage.

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

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

**SUBSCRIBER/MEMBER** means you and each eligible person listed on your application whom we agree to cover.

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

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

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

**WE, US, and OUR** means 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.