Consumer's Right to Know About Health Plans in Rhode Island

Blue Choice New England
BLUE CROSS and BLUE SHIELD OF MASSACHUSETTS, Inc.
February 28, 2008

Consumer Disclosure

Safe and Healthy Lives in Safe and Healthy Communities

Consumer Disclosure

CONSUMER'S RIGHT TO KNOW ABOUT HEALTH PLANS

Blue Choice New England

THE HEALTH CARE ACCESSIBILITY AND QUALITY ASSURANCE ACT

WHY ARE YOU GETTING THIS INFORMATION?

- Knowing how Health Plans work helps you to be a better consumer.
- Meets State Law requiring Health Plans to disclose information.
- Provides information about your specific Health Plan.
- Informs you that a comprehensive list of all participating providers is available to you on the Health Plan Web Site (Hard copies available on request.)

Another document, the *Consumer's Guide to Health Plans in Rhode Island*, gives general information about health plans, including standard definitions of common terms, and is available upon request from Health Plan representatives. This document can also be found on the RI Department of Health Web Site, www.healthri.org.

This Consumer Disclosure has been reviewed and approved by the Rhode Island Department of Health in accordance with R23-17.13 (Rules and Regulations for Certifying Health Plans). Requests for more information about Health Plan certification or consumer rights may be addressed to:

> Rhode Island Department of Health, Division of Health Services Regulation, 3 Capitol Hill, Providence, RI 02908-5097, Phone: 401 222-6015.

Q **Who can I contact at the Health Plan for information?** Representatives of this Health Plan are available to help you get the information you need. You can contact a Health Plan representative at:

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By Telephone: 1-800-262-BLUE or number shown on your identification card. To use the Telecommunications Device for the Deaf: 1-800-522-1254. Customer service hours are Monday through Friday from 8:00 am to 8:00 pm. By Mail: Blue Cross and Blue Shield of Massachusetts, Inc., Member Service, P. O. Box 9134, North Quincy, MA 02171-9134. Internet: www.bluecrossma.com
Para hablar con un representante que hable Espanol, por favor llame el numero de telephono en su tarjeta de identificacion.

Q **How does the Health Plan review and approve covered services?** A Health Plan may review covered services that are recommended by providers to decide if the services are medically necessary. If the plan decides the service is not medically necessary, it will not pay. You and your provider can appeal the Health Plan's decision. For more information about appeals see the Consumer's Guide to Health Plans in Rhode Island.

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All covered services, except routine circumcision, voluntary termination of pregnancy, voluntary sterilization, stem cell ("bone marrow") transplant donor suitability testing and preventative health services, must be medically necessary and appropriate for your specific health care needs. This means that all covered services must be consistent with generally accepted principals of professional medical practice. The Plan decides which covered services are medically necessary and appropriate for you by using guidelines outlined in your subscriber certificate.

Q **What if I have an emergency?** An emergency is a problem that needs to be addressed by a provider "right-away" to prevent permanent damage or death. Here's what this Health Plan wants you to do when you have an emergency health care problem, at home or out of state.

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You do not need a referral from your PCP or approval from the Plan before you obtain emergency medical care. The Plan provides for emergency medical services whether you are in or out of the plan's service area (may include inpatient or outpatient services by provider qualified to furnish emergency medical care and that are needed to evaluate or stabilize your emergency medical condition. At the onset of an emergency medical condition that in your judgment requires emergency medical care, you should go to the nearest emergency room. For assistance, call your local emergency medical service system by dialing the local emergency telephone number. You will not be denied coverage for medical and transportation services described in your Subscriber Certificate that you incur as a result of your emergency medical condition.

Q **What if I refuse a referral to a participating provider? (a doctor, nurse, or other health professional in your Health Plan's network)** (not applicable to single service Health Plans) When a specific covered service is recommended, Health Plans may send you to certain participating providers. If you refuse the referral and get the service from another provider, the Health Plan must tell you what effect it will have on payment.

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In most cases, your PCP will furnish needed health care. If you do need to see a specialist, your PCP will refer you to an appropriate network specialist. Your PCP will obtain approval from the Plan when required. It is up to you to comply with any limits set out in the Plan's referral approval. You must obtain an approved referral from your PCP before you receive most outpatient specialty care from a network specialist in order to receive the highest level of benefits from the Plan. Note: Services that do not require a referral or prior approval are described in the Subscriber Certificate.

Q **Does the Health Plan require that I get a second opinion for any services? What if I want a second opinion?** In some cases the Health Plan may require a second opinion before it will pay for a covered service. Or you may just want a second opinion on a plan for diagnosis or treatment.

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A second opinion is not required by the Plan. The Plan provides coverage for an outpatient second opinion about your medical care by a network physician. This coverage includes a third opinion when the second opinion differs from the first. Remember, as other medical visits, your PCP must refer you to a network physician for these services.

Q **How does the Health Plan make sure that my personal health information is protected and kept confidential?** In general, personal health information must be kept confidential (private) by a Health Plan, its employees and agencies it contracts with. Here's how the Health Plan makes sure that personal health information is protected.

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We are required by law to protect the confidentiality of your personal and medical information. Disclosure only to designated individuals, along with contract obligations, protects your information from unauthorized use. We use safeguards to protect your privacy. Even when allowed, use and disclosure are limited to the minimum amount reasonably necessary for the intended task. Special protections apply to certain medical conditions. For additional information, please call the Member Service toll free number on your ID card or visit our website at www.bluecrossma.com.

Q **How am I protected from discrimination?** You have the right to be treated fairly and equally. Health Plans may not discriminate against you due to age, sex, religion, race or ethnic origin, disability, occupational status or any other characteristics protected by law.

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Blue Cross and Blue Shield of Massachusetts, Inc. as required by state and federal law will not discriminate against any member on the basis of membership in a managed care plan, source of payment, sex, age, race, ethnicity, religion, origin, health status, or handicap in providing health care services.

Q **If I refuse treatment, will it affect my future treatment?** If you refuse to be treated for any condition, your Health Plan must tell you what effect your decision will have on future coverage.

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When you enroll in the Plan, you agree that it is up to your PCP and other network providers to determine the right treatment for your care. You may (for personal or religious reasons) refuse to accept the procedures or treatments advised by your network provider, or you may ask for treatment that a network provider judges does not meet generally accepted professional standards of medical care. You have the right to refuse the treatment advice of the network provider, or to seek other care at your own expense.

Q **How does the health plan pay providers?** Your Health Plan must tell you about the kinds of financial arrangements it has with providers.

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This health plan may include a capitated reimbursement or other similar risk-sharing arrangement and other financial arrangements with your provider.

Q **How is my health insurance coverage renewed or canceled?**

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Coverage is renewed on an annual basis during an open enrollment period. The open enrollment period is the time each year during which eligible persons may enroll for or change coverage in the *Plan* for the next year.

Q **If I am covered by two or more Health Plans, what should I do?** If you or a family member are covered by two or more Health Plans, you may have to give information on your coverage to each Health Plan. This helps the Health Plans to arrange payments between the plans when you or a family member receive a service. Here's what this plan will ask you to tell them.

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The *Plan* will coordinate payment of *covered services* with hospital, medical, dental, health or other plans under which you are covered. Upon e*nrollment, and upon request once you are enrolled, y*ou must also supply the *Plan* with information about other plans that may provide you with coverage for health care services.

Health Benefits Required Under Rhode Island Law as of September 2000:
Health Maintenance Organizations (HMOs) and health insurers in Rhode Island are required by State law to provide enrollees with coverage for certain kinds of health care services. These laws do not apply to Medicare, Medicaid, ERISA self-funded plans or supplemental (e.g. Medigap) or single disease (e.g. Cancer coverage) health insurance policies (check with your workplace benefits administrator. These mandated benefits (see summary list in Consumer's Guide to Health Plans in RI) often apply only under certain circumstances, may be limited to participating providers, and are not always covered in full--other conditions and restrictions not mentioned here may apply. For more information about specific mandated benefits, contact your Health Plan representative or the Rhode Island Department of Business Regulation at 401 222-2223.

Covered Services at a Glance:
The information on the following pages shows you what services are covered under this Health Plan. This is only a summary. You may find complete information in the Official Plan Documents or contact the Health Plan Representative listed on the first page.

Single Service Health Plans (example: dental care, vision care) must provide you with standardized and easy-to-understand information about covered services -- including out-of-pocket costs, service limitations and other things you need to know. Single Service Health Plans can do this through general information materials or by using a special insert summary called "Covered Services at a Glance." For more complete information, read the Official Plan Documents or contact a Health Plan Representative. Using this information, you can compare:

- Health Plans
- Out-of-pocket costs
- Limits on services

Health Plan: Blue Choice New England

COVERED SERVICES AT-A-GLANCE

Annual Deductible: Indiv-$ 0 00/Family-$ 0 .00 **Max Lifetime Cap**: Indiv.-$ 0 ; Family-$ 0

Type of Service (Not All Services are Listed) Call plan or check Official Plan Documents for details	Is Prior Authorization Required (Yes/No)	What Out-of -Pocket Expenses Will I Have to Pay?	What Other Limitations Apply?	If I Choose a Non-Participating Provider Will the Service be Covered?
Ambulance	Emergency-No Other-Yes	None	This health plan covers: Transport to an emergency medical facility for emergency medical care and other medically necessary ambulance transport.	Emergency-Yes Other-20% coinsurance after deductible.
Chiropractic Treatment	No	$10 copayment		Yes, 20% coinsurance after deductible.
Dental Care		All Charges	Not a covered service	No, not covered
Diagnostic X-rays, Imaging and Laboratory Tests	No	None		Yes, 20% coinsurance after deductible
Emergency Services	No	Emergency Room $50 copyament Office/Health Center $10 copayment		Yes
Experimental Treatments		Generally not covered	Experimental treatments not covered. Unless mandated.	No, not covered
Eye Care	No	$10 copayment	One exam every 24 months	Yes, 20% coinsurance after deductible
Foot Care	Referral Required	Hospital and day surgical facility services - No Cost Office Visit - $10 copayment	No coverage for routine foot care	Yes, 20% coinsurance after deductible
Health Education & Wellness	No	Copayments vary	Coverage for Diabetes Education per Rhode Island mandate	Yes

Summary for consumer information only. This is not a contract.

Health Plan: Blue Choice New England

COVERED SERVICES AT-A-GLANCE

Annual Deductible: Indiv-$ 0 .00/Family-$ 0 .00	**Max Lifetime Cap**: Indiv.-$ 0.00 ; Family-$ 0.00

Type of Service (Not All Services Are Listed) Call plan or check Official Plan Documents for details	Is Prior Authorization Required (Yes/No)	What Out-of -Pocket Expenses Will I Have to Pay?s	What Other Limitations Apply?	If I Choose a Non-Participating Provider Will the Service be Covered?
Home Health Care	Yes	None	Provided for defined medical goal and when patient is unable to travel to a treatment site.	Yes, 20% coinsurance after deductible
Hospice Care	Yes	None	Provided when a patient has a terminal illness and is expected to live six months or less.	Yes, 20% coinsurance after deductible
Hospitalization and Inpatient Services	Yes	None		Yes, 20% coinsurance after deductible
Maternity	Yes	None		Yes, 20% coinsurance after deductible
Medical Equipment and Supplies	Yes	No cost up to benefit limit, then all charges	$1,500 maximum per member per calendar year. These benefits are provided for the least expensive equipment of its type that meets the member's needs.	Yes, 20% coinsurance after deductible
Mental Health, Inpatient	Yes	None	Non-biologically based Mental Conditions: up to 60 days per calendar year (unlimited days in a General Hospital).	Yes, 20% coinsurance after deductible
Mental Health, Outpatient	No, for visits 1-12; Yes, for 12 or more visits	$10 copayment	Non-biologically based Mental Conditions up to 24 visits per calendar year	Yes, 20% coinsurance after deductible
Nursing Home Care		All charges	Not a covered service	No, not covered

Health Plan: Blue Choice New England

COVERED SERVICES AT-A-GLANCE

Annual Deductible: Indiv-$ .00/Family-$ .00	**Max Lifetime Cap**: Indiv.-$; Family-$

Type of Service (Not All Services Are Listed) Call plan or check Official Plan Documents for details	Is Prior Authorization Required (Yes/No)	What Out-of -Pocket Expenses Will I Have to Pay?	What Other Limitations Apply?	If I Choose a Non-Participating Provider Will the Service be Covered?
Physician Office Visits	Referral from PCP required for specialist	$10 copayment	No coverage is provided for a service or supply that is not described as a covered service in the subscriber certificate	Yes, 20% coinsurance after deductible
Prescription Drugs/Devices	For certain drugs, prior approval is required	Retail Pharmacy $10 copay (generic); $25 copay (preferred brand-name); $45 copay (non-preferred)	Up to a 30-day supply retail and a 90-day supply mail order	No, except when traveling outside the service area and network retail pharmacy is not reasonably available
Rehabilitation (PT/OT/Speech Therapy)	Yes	$10 copayment	Up to 60 visits per member per calendar year	Yes, 20% coinsurance after deductible
Substance Abuse, Inpatient	Yes	None	Alcoholism Treatment: 30 days per calendar year (unlimited days in a General Hospital)	Yes, 20% coinsurance after deductible
Substance Abuse, Outpatient	No for visits 1-12; Yes, for 12 or more visits	$10 copayment	Alcoholism Treatment: 8 visits per member per year	Yes, 20% coinsurance after deductible
Surgery, Outpatient	Yes	$10 copayment for office setting		Yes, 20% coinsurance after deductible
Second Opinion	Referral from PCP required for specialist	$10 copayment		Yes, 20% coinsurance after deductible