Certificate of Coverage

Neighborhood Health Plan of Rhode Island

Neighborhood PREMIER
Small Group Market
HealthSource RI Plan
For Small Employers

WELCOME!

Welcome to Neighborhood Health Plan of Rhode Island (Neighborhood). Thank you for joining us!

This booklet is your Certificate of Coverage. In it, you will find:

- Information regarding your coverage as a Neighborhood member
- Helpful tips
- Phone numbers and other contact information about Neighborhood
- A list of words and their meanings

Neighborhood is a Rhode Island not-for-profit, tax-exempt 501(c)3 corporation formed by Rhode Island's community health centers.

Sincerely,

Peter Marino
Chief Executive Officer

Legal Notice

This Certificate of Coverage is a legal agreement between you and Neighborhood. You will receive a member ID card and number. Use the card when you get health care services covered under this agreement.

By presenting your member ID card for covered services, you agree to follow the rules and obligations of this agreement.

This agreement is solely between you and Neighborhood.

PLEASE READ AND SAVE THIS DOCUMENT

This booklet is your **Certificate of Coverage** with Neighborhood. It explains the benefits of your plan.

- This booklet gives you the details about your health care.
- It explains how to get coverage for the health care services you need.
- This is an important legal document. Keep it in a safe place.

Helpful Tips

- Pay attention to the "⇒" symbol, this indicates something important.
- Read this booklet. Get to know what your plan covers and what it does not (see Chapter 4, Covered Medical and Prescription Drug Benefits).
- Many important words are highlighted in **bold** throughout this document. Additionally, a list of health care related words and their meanings are in the Glossary (see Chapter 9). If you need assistance in understanding how these words apply to you or your plan, please call Neighborhood Member Services at 1-855-321-9244.
- Once enrolled with Neighborhood, you will receive a member ID card in the mail. Your member ID card lets your providers, the pharmacy, laboratory, or hospital know that you are a Neighborhood member so that they can help access the care and services you are eligible to receive.
- If you lose your member identification (ID) card, call Neighborhood Member Services at 1-855-321-9244 right away. We will mail a new card to you.
- Do not let anyone use your Neighborhood member ID card or your children's cards.
- Letting someone borrow your member ID card is against the law.
- As a member, you can choose from thousands of providers, specialists, and other health care providers in Rhode Island.
- Always make sure that the health care providers you choose are from our list of network providers. This list can change. To find out which providers are in our network:
    1. Go to www.nhpri.org and search our online directory by clicking on "Find a Doctor."

2. Call Neighborhood Member Services at 1-855-321-9244 to request a paper copy of our network providers.

⇒ Be an active participant in your health care. Ask providers about treatment plans and their costs. Use the preventive health care services we cover to stay well.

TELEPHONE NUMBERS

AND OTHER CONTACT INFORMATION

Call	**1-855-321-9244 Neighborhood Member Services** **1-833-470-0578 Behavioral Health Member Services** **1-800-843-3582 Delta Dental of Rhode Island Customer Service** • Neighborhood Member Service Specialists are available Monday through Friday 8:00 am to 6:00 pm • Free language interpreter services available for non-English speakers when calling Neighborhood Member Services • Calls to this number are free
TTY	**Dial 711** • Neighborhood Member Service Specialists are available Monday through Friday 8:00 am to 6:00 pm • This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking • Calls to this number are free
Fax	**1-401-459-6021**
Write	**Neighborhood Health Plan of Rhode Island** **910 Douglas Pike** **Smithfield, RI 02917**
Website	www.nhpri.org

IMPORTANT PLAN DETAILS

Emergency Care

Neighborhood covers all medical emergencies. An **emergency** is a situation that is life threatening, involves severe pain, or can cause serious harm to your body or health if you do not receive treatment right away.

Examples of some types of emergencies are: broken bones, poisoning or swallowing a dangerous substance, drug overdose, very bad pain or pressure, bleeding that will not stop, severe trouble breathing, change in level of consciousness, bad head injury, seizures (or a change in pattern of seizures), complications of pregnancy such as persistent bleeding or severe pain, and thoughts of harming yourself or others.

What if You Have a Medical Emergency?

- Get help as quickly as possible.
- Call 911 for help or go to the nearest **emergency room** or hospital. Call for an ambulance if you need it.
- You do not need to get approval or a referral first from your PCP.
- The hospital does not need to be part of Neighborhood's network.

Calling Neighborhood Member Services

Call Neighborhood Member Services at 1-855-321-9244 for:

- General questions
- Help in choosing a primary care provider (PCP)
- Benefit questions
- Enrollment questions
- Questions about medical bills
- Available Monday through Friday 8:00 am to 6:00 pm
- Services for hearing impaired members

For Members Who Have Difficulties with Hearing or Speaking

Dial 711.

Services for Behavioral Health and Substance Use

Neighborhood offers behavioral health and substance use benefits). If you have any questions, please call **1-833-470-0578**. This number is also on your Neighborhood member ID card and available 24 hours a day, 7 days a week to help you.

Services for Pediatric Dental Benefits

Neighborhood offers pediatric dental benefits, through our partner Delta Dental of Rhode Island (Delta Dental). To utilize pediatric dental services, you will need to use your Delta Dental ID card. If you have any questions, please call Delta Dental at 1-800-843-3582. Delta Dental Customer Service is available Monday through Thursday 8a.m. to 7p.m., ET and Fridays from 8a.m. to 5p.m., ET. You may call Delta Dental's automated information line 24 hours a day, seven days a week.

Our Website

Find information about Neighborhood online at www.nhpri.org:

- Provider directory
- What medicines are covered
- Special programs and much more

Grievance and Appeals (see Chapter 6)

If you need to call us about a complaint or appeal, please call Neighborhood Member Services at 1-855-321-9244. To submit a complaint or appeal in writing, please send your letter to:

Grievance and Appeals Unit
Neighborhood Health Plan of Rhode Island
910 Douglas Pike
Smithfield, RI 02917

For Behavioral Health appeal, please call **1-833-470-0578**, To submit an appeal in writing, please send your letter to:

Optum
Attn: Appeals
P.O. Box 30512
Salt Lake City, UT 84130-0512

For Delta Dental call 1-800-843-3582 or 401-752-6100 to submit a complaint or email customerservice@deltadentalri.com. To submit an appeal, send your appeal to:

Delta Dental of Rhode Island
Attn: Appeals
P.O. Box 1517
Providence, RI02901-1517

Telephone Interpreters

Neighborhood has free language interpreter services available to answer questions from non-English speaking members when calling our Neighborhood Member Services at 1-855-321-9244. For information, please call Neighborhood Member Services at 1-855-321-9244.

Preauthorization

Neighborhood pays for health care services that are deemed medically necessary. If a service is not in this booklet, it is not covered. Any services that need preauthorization are noted in the **Summary of Medical and Prescription Drug Benefits** chart in Chapter 3. Please see Chapter 3 for an explanation of preauthorizations.

HealthSource RI

HealthSource RI is Rhode Island's Health Benefits Exchange established as part of the Patient Protection and Affordable Care Act (ACA). HealthSource RI handles all eligibility determinations for this plan. Neighborhood enrolls members once HealthSource RI has determined they are eligible for coverage by a plan offered through the marketplace. For information about who is eligible to enroll, effective dates of coverage, how to add or remove family members, or how to disenroll, please visit **www.healthsourceri.com** or call HealthSource RI at 1-855-840-HSRI (4774).

TABLE OF CONTENTS

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter.

CHAPTER 1 SUMMARY OF MEDICAL AND PRESCRIPTION DRUG BENEFITS

SECTION 1 EXPLANATION OF MEMBER COST-SHARING AND BENEFIT LIMITS

This section explains information about cost-sharing and benefit limits for your Neighborhood PREMIER plan. This includes deductibles, co-insurance, co-payments, out-of-pocket maximums, and limitations on the amount of certain services the plan will pay for.

When you see a provider or other health care provider in our network, your Neighborhood PREMIER plan will pay most of the cost and you pay a portion. The portion of the cost that is paid directly to a provider by a member is called **cost-sharing**. All of a member's cost-sharing taken together is called the **out-of-pocket** expenses.

Some services are covered with no out-of-pocket charge to you. Other services may require a meeting a deductible, paying co-insurance, or paying a co-payment. Each benefit year, there is a limit on how much you pay out-of-pocket for services.

For some preventive services and screenings there are no out-of-pocket charges at the time of service.

If a member receives preauthorization for a service received outside of the contracted network, the member may be balance billed and be responsible for the difference between the amount Neighborhood pays and the provider's billed charge.

There may be situations in which our allowance for a covered health care service is less than the amount of your co-payment and deductible (if any). In this situation, you will be responsible to pay up to our allowance when services are rendered by a network provider.

⇒ Please see Chapter 4 for details on medical benefits, including what services are not covered.

CHAPTER 1 SUMMARY OF MEDICAL AND PRESCRIPTION DRUG BENEFITS

Section 1.1 Deductibles and Co-Insurance

The **deductible** is the amount the member (you) and, if applicable, the enrolled members of your family are required to pay in a benefit year for certain covered services before your Neighborhood PREMIER plan will start paying for them. This amount is paid directly to the provider(s). Provider(s) may also send you a bill for this amount.

The **family plan deductible** applies for all enrolled members of a family. All amounts paid by enrolled members toward their **individual plan deductibles** go toward the family plan deductible. The family plan deductible is met in a benefit year when one or more additional enrolled members in that family have paid toward their individual plan deductibles, a collective amount equal to the balance of the family plan deductible in any combination.

Once the family plan deductible has been met during a benefit year, all enrolled members in a family will thereafter have met their individual plan deductibles for the remainder of the benefit year.

Co-insurance is an amount you are required to pay as your share of the cost for services which are subject to the deductible. Once an individual has met their individual plan deductible, or the family as a whole has met the family plan deductible, you will be responsible for paying the co-insurance for covered services subject to the deductible. Co-insurance is usually a percentage (for example, 0%).

⇒ Please see Section 2 of this chapter for details on your deductible.

Services subject to the deductible and co-insurance will be indicated in and the Summary of Medical Benefits chart (Section 3) and Summary of Prescription Drug Benefits chart (Section 4 of this chapter).
Your contributions to the deductible, co-insurance and co-payments will go toward the out-of-pocket maximum described in Section 1.3 of this chapter.

Example

You may be required to meet a $2,300 deductible for certain services in a benefit year. Once you meet your deductible, you may be charged 0% of the amount charged by the provider, and Neighborhood will pay the rest of the bill directly to the provider.

Note
The deductible does not apply to preventive services/screenings.

Section 1.2 Co-Payments

Under your Neighborhood PREMIER plan, you may be required to pay a **co-payment** for some covered services. A co-payment is a fixed amount you and members of your family pay for a specific service. The co-payment is due at the time of service or your provider may send you a bill.

The co-payment amount is the same every time you visit that provider.

⇒ Please see the Summary of Medical Benefits (Section 3) and the Summary of Prescription Drug Benefits (Section 4) of this chapter for details on co-payments for specific services.

Your co-payments will go toward the **out-of-pocket maximum** described in Section 1.3 of this chapter.

Example

When you see a certain type of specialist provider, you may be asked to pay $55. Neighborhood will pay the rest of the bill directly to the provider. This will be the same for every visit.

Section 1.3 Out-of-Pocket Maximum

Your Neighborhood PREMIER plan has individual plan and family plan **out-of-pocket (OOP) maximums**.

An OOP maximum is the most you or another member of your family can be charged for deductibles, co-insurance, and co-payments in a benefit year. Monthly premiums do not count toward the out-of-pocket maximum.

Your Neighborhood PREMIER plan has an individual plan OOP maximum for each person and an overall family plan OOP maximum.

Individual Plan OOP Maximum

Once an individual meets their individual plan OOP maximum, he or she will not have to pay anything more for covered services for the remainder of the benefit year.

Family Plan OOP Maximum

Once the members of your family have reached the family plan OOP maximum, all members will no longer be responsible for deductibles, co-insurance, or co-payments for covered services for the remainder of the benefit year (even if a member has not met their individual plan OOP maximum).

⇒ Please see Section 2 of this chapter for details on your OOP maximum.

Example

You may have a $5,500 OOP maximum. Once you reach your OOP maximum, you will not be charged a deductible, co-insurance, or co-payment for covered services for the remainder of the benefit year.

Section 1.4 Benefit Limits

Benefit Limits

For some services, your Neighborhood PREMIER plan may limit the dollar amount, the duration, or the number of visits for covered health care services. For services beyond this amount you will be required to pay out-of-pocket to the network provider. This is known as a **benefit limit**. You will be responsible for any expenses that exceed the designated benefit limit.

⇒ Please see Section 2 of this chapter for information about which services have benefit limits.

Example

Your plan allows 12 visits to an in network acupuncturist per benefit year.. For services beyond that amount, the member is responsible.

Section 1.5 Preauthorization

Preauthorization

Your Neighborhood PREMIER plan may require you to get permission before you receive certain services. This is called **preauthorization.** If you receive preauthorization, it means your plan has decided that a health care service, treatment plan, prescription drug, or durable medical equipment is **medically necessary**. This means that the services, supplies, or drugs needed for the prevention, diagnosis, or treatment of your medical condition, meet accepted standards of medical practice.

⇒ Please see Section 3 of this chapter for information on which benefits require preauthorization.

You may ask for preauthorization by telephone. We recommend you contact us as soon as possible, but within 3 business days for any covered health care services you have obtained, for which preauthorization is required. For covered health care services (other than behavioral health services), call Neighborhood Member Services at 1-855-321-9244. For Behavioral Health Services, please call 1-833-470-0578.

For medical, behavioral health and substance abuse services which require preauthorization, if you or your provider do not get preauthorization and the services are determined to be not medically necessary or the setting in which the services were received is determining to be inappropriate, we will not cover these services/facilities and you will be responsible for the cost of these services.

Example

Your provider may decide you need to receive care from a certain type of specialist who requires a preauthorization. You must call Neighborhood in advance of seeing this provider.

Preauthorization is not a guarantee of payment, as the process does not consider benefit limits or eligibility at the time of the service.

⇒ For more information on preauthorization, please see Chapter 3, Section 1.

CHAPTER 1 SUMMARY OF MEDICAL AND PRESCRIPTION DRUG BENEFITS

SECTION 2 SUMMARY OF MEMBER DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS

Deductibles

You pay the following amounts each benefit year before your Neighborhood PREMIER plan starts to pay toward the cost of services subject to the deductible:

Individual Plan Deductible	$2,300
Family Plan Deductible	$4,600

Out-of-Pocket Maximums

To protect you, your Neighborhood PREMIER plan limits how much you could pay out-of-pocket for health care services.

The following is the most you would pay for deductibles, co-insurance, and co-payments each benefit year:

Individual Plan Out-of-Pocket Maximum	$5,500
Family Plan Out-of-Pocket Maximum	$11,000

CHAPTER 1 SUMMARY OF MEDICAL AND PRESCRIPTION DRUG BENEFITS

SECTION 3 SUMMARY OF MEDICAL BENEFITS

The **Summary of Medical Benefits** provides information on what type of member cost-sharing applies (if any) to covered benefits. Remember that you must use a network provider for covered services unless it is an emergency or an urgent care situation, or if you receive a preauthorization.

How to Read the Summary of Benefits Chart

Each column of the chart contains important information about the services covered by your plan.

Here is an explanation of each column:

What Are My Benefits? This column names the category of medical services being described.

Subject to Deductible? This column tells you if the category of services requires you to meet the deductible.

What is my Co-Insurance? This column tells you what the coinsurance for this service will be once you have met your deductible.

What is My Co-Payment? This column tells you if this service requires a co-payment at the time of your visit to a provider.

Is Preauthorization Required? This column tells you if you need to receive preauthorization before receiving this service.

Is there a Benefit Limit? This column tells you if there is a limitation on this service.

Where Can I Find More Details? This column tells you where to go in the Certificate of Coverage to find more information about this service.

⇒ Please see Chapter 4 for details on medical benefits, including what services are not covered.

⇒ In the **Summary of Medical Benefits** chart, some items are marked with the phrase "Preauthorization rules may apply**".** This means that, in some instances, a member will need preauthorization before receiving these services. Preauthorization may be dependent upon other criteria like diagnosis, setting, member age etc.

- Please call member services for more details regarding a particular service.
- You may also refer to Chapter 3, Section 1, for more information on preauthorizations.

WHAT ARE MY BENEFITS?	SUBJECT TO DEDUCTIBLE?	WHAT IS MY CO-INSURANCE?	WHAT IS MY CO-PAYMENT?	IS PREAUTHORIZATION REQUIRED?	IS THERE A BENEFIT LIMIT?	WHERE CAN I FIND MORE DETAILS?
EMERGENCY AND URGENT CARE SERVICES						
Ambulance Services and Emergency Transportation	Yes- with $50 maximum per trip	0% with $50 maximum per trip	Not Applicable	No preauthorization required for emergency transportation. Non-emergency ambulance transportation for medically necessary care is covered when the member's medical condition prevents safe transportation by any other means. Requires preauthorization.		Chapter 4 Section 1.1
Treatment in an Emergency Room (ER)	Yes	Not Applicable	$250 after deductible	No		Chapter 4 Section 1.1
Urgent Care Treatment in Urgent Care Centers, Facilities, or Providers Office	No	Not Applicable	$55	No		Chapter 4 Section 1.1
Dental Emergency	Yes	Not Applicable	$250 after deductible	No		Chapter 4 Section 1.1

CHAPTER 1 SUMMARY OF MEDICAL AND PRESCRIPTION DRUG BENEFITS

WHAT ARE MY BENEFITS?	SUBJECT TO DEDUCTIBLE?	WHAT IS MY CO-INSURANCE?	WHAT IS MY CO-PAYMENT?	IS PREAUTHORIZATION REQUIRED?	IS THERE A BENEFIT LIMIT?	WHERE CAN I FIND MORE DETAILS?
OUTPATIENT CARE AND AMBULATORY PATIENT SERVICES						
Acupuncture	No	Not Applicable	$55	Yes	The benefit is limited to 12 visits per benefit year.	Chapter 4 Section 1.2
Allergy Testing	Yes	0%	Not Applicable	Preauthorization rules may apply		Chapter 4 Section 1.2
Blood and Blood Services	Yes	0%	Not Applicable	No		Chapter 4 Section 1.2
Chemotherapy	Yes	0%	Not Applicable	Preauthorization rules may apply		Chapter 4 Section 1.2
Chiropractic Care	No	Not Applicable	$55	Yes	The benefit is limited to 12 visits per benefit year.	Chapter 4 Section 1.2
Clinical Trials	Yes	0%	Not Applicable	Yes		Chapter 4 Section 1.2
Contraceptive Services	Not Applicable	Not Applicable	Not Applicable	No	No	Chapter 4 Section 1.2

WHAT ARE MY BENEFITS?	SUBJECT TO DEDUCTIBLE?	WHAT IS MY CO-INSURANCE?	WHAT IS MY CO-PAYMENT?	IS PREAUTHORIZATION REQUIRED?	IS THERE A BENEFIT LIMIT?	WHERE CAN I FIND MORE DETAILS?
Diabetes Services	Yes	0%	Not Applicable	Preauthorization rules may apply for Diabetes Supplies	204 Glucose Test Strips per 25 days.	Chapter 4 Section 1.2
Diagnostic Imaging and Machine Tests	Yes	0%	Not Applicable	Preauthorization rules may apply		Chapter 4 Section 1.2
Durable Medical Equipment	Yes	0%	Not Applicable	Preauthorization rules may apply		Chapter 4 Section 1.2
Early Intervention Services	[x]	Not Applicable	Not Applicable	No	In accordance with Rhode Island General Laws §27-18-64	Chapter 4 Section 1.2

WHAT ARE MY BENEFITS?		SUBJECT TO DEDUCTIBLE?	WHAT IS MY CO-INSURANCE?	WHAT IS MY CO-PAYMENT?	IS PREAUTHORIZATION REQUIRED?	IS THERE A BENEFIT LIMIT?	WHERE CAN I FIND MORE DETAILS?
Habilitative Services		No	Not Applicable	$55	No	Physical Therapy is limited to 24 visits per benefit year. Occupational Therapy is limited to 24 visits per benefit year. Speech Therapy is limited to 24 visits per benefit year.	Chapter 4 Section 1.2
Hearing Services	Hearing Exams	No	Not Applicable	$55	No	In accordance with State of Rhode Island General Laws § 27-41-63: Coverage limited to 1 individual hearing aid, per ear, per every 3 years	Chapter 4 Section 1.2
	Hearing Aid Other Services	No	Not Applicable	$55			

WHAT ARE MY BENEFITS?		SUBJECT TO DEDUCTIBLE?	WHAT IS MY CO-INSURANCE?	WHAT IS MY CO-PAYMENT?	IS PREAUTHORIZATION REQUIRED?	IS THERE A BENEFIT LIMIT?	WHERE CAN I FIND MORE DETAILS?
	Hearing Aids	Yes	0%	Not Applicable			
Hemodialysis Services		Yes	0%	Not Applicable	No		Chapter 4 Section 1.2
Home Health Care		Yes	0%	Not Applicable	Yes		Chapter 4 Section 1.2
Hospice		Yes	0%	Not Applicable	No		Chapter 4 Section1.2
Immunizations		Not Applicable	Not Applicable	Not Applicable	No		Chapter 4 Section 1.2
Infertility Services		Yes	0%	Not Applicable	Yes	Up to eight cycles per lifetime for covered infertility procedures.	Chapter 4 Section 1.2

WHAT ARE MY BENEFITS?	SUBJECT TO DEDUCTIBLE?	WHAT IS MY CO-INSURANCE?	WHAT IS MY CO-PAYMENT?	IS PREAUTHORIZATION REQUIRED?	IS THERE A BENEFIT LIMIT?	WHERE CAN I FIND MORE DETAILS?
Injectable, Infused or Inhaled Medications	Yes	0%	Not Applicable	Preauthorization rules may apply		Chapter 4 Section 1.2
Laboratory Tests	Not Applicable-for preventive lab tests Yes- for non-preventive lab tests	Not Applicable 0%	Not Applicable Not Applicable	Preauthorization rules may apply Preauthorization rules may apply	• Human Leukocyte antigen or histocompatibility locus testing: Coverage limited to establishing member suitability for bone marrow transplant; one test per lifetime for each member. Cystic Fibrosis genetic carrier testing is limited to one test per lifetime for each member.	Chapter 4 Section 1.2
Lead Screenings	Not Applicable	Not Applicable	Not Applicable	No		Chapter 4 Section 1.2

WHAT ARE MY BENEFITS?	SUBJECT TO DEDUCTIBLE?	WHAT IS MY CO-INSURANCE?	WHAT IS MY CO-PAYMENT?	IS PREAUTHORIZATION REQUIRED?	IS THERE A BENEFIT LIMIT?	WHERE CAN I FIND MORE DETAILS?
Medical Supplies	Yes	0%	Not Applicable	Preauthorization rules may apply		Chapter 4 Section 1.2
Nutritional Counseling	Not Applicable	Not Applicable	Not Applicable	No		Chapter 4 Section 1.2
Outpatient Surgery	Yes	0%	Not Applicable	Preauthorization rules may apply		Chapter 4 Section 1.2
Podiatrist Services	No	Not Applicable	$55	No		Chapter 4 Section 1.2
Prevention and Early Detection Services	Not Applicable	Not Applicable	Not Applicable	No		Chapter 4 Section 1.2
Primary Care Services (Including Preventive Care, Gynecologic Exams)	Not Applicable	Not Applicable	Not Applicable	No		Chapter 4 Section 1.2
Primary Care Services to Treat Illness or Injury	No	Not Applicable	$20	No		Chapter 4 Section 1.2

WHAT ARE MY BENEFITS?	SUBJECT TO DEDUCTIBLE?	WHAT IS MY CO-INSURANCE?	WHAT IS MY CO-PAYMENT?	IS PREAUTHORIZATION REQUIRED?	IS THERE A BENEFIT LIMIT?	WHERE CAN I FIND MORE DETAILS?
Private Duty Nursing	Yes	0%	Not Applicable	Yes		Chapter 4 Section 1.2
Prosthetic and Orthotic Devices	Yes	0%	Not Applicable	Preauthorization rules may apply	Hair Prosthetic: The scalp hair prosthesis or wig benefit is limited to members when worn for hair loss suffered as a result of cancer treatment in accordance with State of Rhode Island General Laws § 27-18-67.	Chapter 4 Section 1.2
Radiation Therapy	Yes	0%	Not Applicable	Preauthorization rules may apply		Chapter 4 Section 1.2
Rehabilitative Services and Devices	No	Not Applicable	$55	Yes		Chapter 4 Section 1.2
Smoking Cessation Counseling Services	Not Applicable	Not Applicable	Not Applicable	No		Chapter 4 Section 1.2

WHAT ARE MY BENEFITS?	SUBJECT TO DEDUCTIBLE?	WHAT IS MY CO-INSURANCE?	WHAT IS MY CO-PAYMENT?	IS PREAUTHORIZATION REQUIRED?	IS THERE A BENEFIT LIMIT?	WHERE CAN I FIND MORE DETAILS?
Special Medical Formulas	Yes	0%	Not Applicable	Yes		Chapter 4 Section 1.2
Specialty Care Services	No	Not Applicable	$55	No		Chapter 4 Section 1.2
Termination of Pregnancy	Yes	0%	Not Applicable	No		Chapter 4 Section 1.2
Vision Care (for members age 19 and over)	No	Not Applicable	$55	Preauthorization rules may apply		Chapter 4 Section 1.2
Vision Hardware (for members age 19 and over)	No	Not Applicable	Up to $150 reimbursement once per calendar year		One pair of frames and lenses or one pair of contact lenses covered every benefit year	Chapter 4 Section 1.2
Wellness Benefit	Not Applicable	Not Applicable	Not Applicable	No		Chapter 4 Section 1.2

CHAPTER 1 SUMMARY OF MEDICAL AND PRESCRIPTION DRUG BENEFITS

WHAT ARE MY BENEFITS?	SUBJECT TO DEDUCTIBLE?	WHAT IS MY CO-INSURANCE?	WHAT IS MY CO-PAYMENT?	IS PREAUTHORIZATION REQUIRED?	IS THERE A BENEFIT LIMIT?	WHERE CAN I FIND MORE DETAILS?
INPATIENT CARE AND HOSPITALIZATION						
Hospital Services	Yes	0%	Not Applicable	Yes		Chapter 4 Section 1.3
Inpatient Rehabilitative Services	Yes	0%	Not Applicable	Yes		Chapter 4 Section 1.3
Mastectomy Reconstructive Surgery, and Procedures	Not Applicable	Not Applicable	Not Applicable	Yes		Chapter 4 Section 1.3
Skilled Care in a Nursing Facility	Yes	0%	Not Applicable	Yes		Chapter 4 Section 1.3
Solid Organ and Hematopoietic Stem Cell Transplants	Yes	0%	Not Applicable	Yes		Chapter 4 Section 1.3
PRENATAL CARE, MATERNITY CARE, DELIVERY, AND POSTPARTUM CARE						
Prenatal Care and Postpartum Care	Not Applicable	Not Applicable	Not Applicable	No		Chapter 4 Section 1.4

WHAT ARE MY BENEFITS?	SUBJECT TO DEDUCTIBLE?	WHAT IS MY CO-INSURANCE?	WHAT IS MY CO-PAYMENT?	IS PREAUTHORIZATION REQUIRED?	IS THERE A BENEFIT LIMIT?	WHERE CAN I FIND MORE DETAILS?
Maternity Care and Delivery	Yes	0%	Not Applicable	Yes		Chapter 4 Section 1.4
Well Baby Care and Visits	Not Applicable	Not Applicable	Not Applicable	No		Chapter 4 Section 1.4
Hearing Loss Screening in Newborns	Not Applicable	Not Applicable	Not Applicable	No		Chapter 4 Section 1.4
PEDIATRIC CARE (FOR MEMBERS AGE 18 AND UNDER)						
Pediatric Primary and Preventative Care	Not Applicable	Not Applicable	Not Applicable	No		Chapter 4 Section 1.5

WHAT ARE MY BENEFITS?	SUBJECT TO DEDUCTIBLE?	WHAT IS MY CO-INSURANCE?	WHAT IS MY CO-PAYMENT?	IS PREAUTHORIZATION REQUIRED?	IS THERE A BENEFIT LIMIT?	WHERE CAN I FIND MORE DETAILS?
Pediatric Vision Care Services	No	Not Applicable	$55	Yes Not required for routine annual exam	• One routine eye exam per contract year is covered • One comprehensive low vision evaluation every 5 years • Low Vision follow-up care: four visits in any five-year period	Chapter 4 Section 1.5
Pediatric Eyewear	No	0%	Not Applicable	Yes	• One pair of frames and lenses or one pair of contact lenses covered every benefit year	Chapter 4 Section 1.5
OUTPATIENT SERVICES FOR BEHAVIORIAL HEALTH AND SUBSTANCE USE CARE						
Outpatient Office Behavioral Health Services	No	Not Applicable	$20	Preauthorization rules may apply. Please see Chapter 4 Section 1.6		Chapter 4 Section 1.6

WHAT ARE MY BENEFITS?	SUBJECT TO DEDUCTIBLE?	WHAT IS MY CO-INSURANCE?	WHAT IS MY CO-PAYMENT?	IS PREAUTHORIZATION REQUIRED?	IS THERE A BENEFIT LIMIT?	WHERE CAN I FIND MORE DETAILS?
Outpatient Other Behavioral Health Services	Yes	0%	Not Applicable	Preauthorization rules may apply. Please see Chapter 4 Section 1.6		Chapter 4 Section 1.6
INPATIENT SERVICES FOR BEHAVIORIAL HEALTH AND SUBSTANCE USE CARE						
Inpatient Behavioral Health Services	Yes	0%	Not Applicable	Yes		Chapter 4 Section 1.6

CHAPTER 1 SUMMARY OF MEDICAL AND PRESCRIPTION DRUG BENEFITS

SECTION 4 SUMMARY OF PRESCRIPTION DRUG BENEFITS

Prescription Drug Coverage

Your Neighborhood PREMIER plan covers formulary prescription drugs and includes both acute care and maintenance drugs. Prescription drugs are covered for up to 30-day supply. You need to obtain these drugs directly from a Neighborhood network retail pharmacy or through a Specialty vendor when indicated. A 90-day supply may be available for certain medications. Please see Chapter 4 Section 2.1 for more information.

Cost-Sharing for Prescription Drugs

Covered prescription medications are divided into six tiers.

	Subject to Deductible?	**Co-Payment** (For 30-Day Supply)	**Description**
Tier 1 Drugs	No	$5	Low Cost Maintenance Generics
Tier 2 Drugs	No	$10	Other Generics
Tier 3 Drugs	No	$35	Preferred Brands Maintenance
Tier 4 Drugs	No	$50	Brands
Tier 5 Drugs	No	$200	High Cost and Specialty
Tier 6 Drugs	No	$200	Covered Non Preferred

Formulary

Neighborhood publishes a list of all the drugs that are covered. This list is called a **formulary**. Our formulary can be found at our website at www.nhpri.org or you can call Neighborhood Member Services at 1-855-321-9244.

⇒ Please see Chapter 4, Section 2 for details on Neighborhood's formulary, pharmacy management programs and other details about your prescription drug benefits.

Generic Incentive Program

Your provider may prescribe a brand-name drug that has a generic equivalent. This can happen in Rhode Island and many other states. In this case, you will receive the generic drug and pay the applicable co-payment.

Contraceptives

Contraceptives covered under the Prescription Drug benefit have no cost-sharing.

You must fill your prescriptions at a Neighborhood network pharmacy. Most pharmacies in Rhode Island are part of our network. This also includes additional pharmacies nationwide.

How to Fill Prescriptions

When you fill a prescription, be sure to have your member ID. You may need to pay your deductible and co-payment, if applicable.

- The cost of your prescription may be less than your co-payment. In this case, you only need to pay the actual cost of the prescription.
- If you have any problems using this benefit at a Neighborhood network retail pharmacy, please call Neighborhood Member Services.

⇒ Only Neighborhood network retail pharmacies will honor your Prescription Drug Benefit. In cases where you obtained drugs from a pharmacy other than a Neighborhood pharmacy due to an emergency, call Neighborhood Member Services at 1-855-321-9244. They can explain how to submit your prescription drug claims for payment.

Complaints and Appeals Related to Prescription Drugs

Members must follow the complaints and appeals process for any adverse benefit determination related to formulary exceptions/non-covered prescription drugs. Please see Chapter 6 for details.

CHAPTER 1 SUMMARY OF MEDICAL AND PRESCRIPTION DRUG BENEFITS

SECTION 4 SUMMARY OF PEDIATRIC DENTAL BENEFITS

Pediatric Dental Benefits Coverage

Your Neighborhood PREMIER plan covers pediatric dental services that are outlined by the Essential Health Benefits (EHB) benchmark plan in Rhode Island. These services are for members under the age of 19 years old. These services are deemed essential under the federal Affordable Care Act. This plan is administered on our behalf by Delta Dental of Rhode Island.

Pre-Treatment Estimate

When treatment is likely to cost more than $300, you and your dentist are strongly encouraged to get an estimate before you receive treatment. This includes treatment such as crowns; periodontic; and prosthodontic services.

Prior Authorization Prior Authorization is required for medically necessary orthodontic treatment. The treatment must meet the criteria set forth by the Plan Administrator. No payment will be made if prior authorization is not obtained.

After your dentist sends a request for an estimate or authorization, the Plan Administrator will review the treatment plan. After reviewing the treatment plan, the Plan Administrator will tell you and your dentist what the estimated payment will be for those services.

NOTE: Estimates are based on available benefits. The patient must be a Delta Dental member at the time the service is done. The estimate shows what money is available at the time the estimate is done. Estimates can change because services may no longer be available on the date the service is done. For example, if you had other services paid for after the estimate, and you reach your annual maximum, there will be no money left to pay for the new service. Another example is if you lose coverage before the new service is finished.

Cost-Sharing for Pediatric Dental Benefits

PROCEDURE	SUBJECT TO DEDUCTIBLE?	WHAT IS MY CO-INSURANCE?	FREQUENCY/LIMITATIONS*	IS PRIOR AUTHORIZATION REQUIRED?	IS PRE-TREATMENT ESTIMATE RECOMMENDED?	WHERE CAN I FIND MORE DETAILS?
DIAGNOSTIC						
Oral Exam	No	0%	Twice per calendar year	No	No	Chapter 4 Section 3
Bitewing x-rays	No	0%	Two sets per calendar year	No	No	Chapter 4 Section 3

PROCEDURE	SUBJECT TO DEDUCTIBLE?	WHAT IS MY CO-INSURANCE?	FREQUENCY/LIMITATIONS*	IS PRIOR AUTHORIZATION REQUIRED?	IS PRE-TREATMENT ESTIMATE RECOMMENDED?	WHERE CAN I FIND MORE DETAILS?
Complete x-ray series or panoramic film	No	0%	Once every 60 months	No	No	Chapter 4 Section 3
Single x-rays	No	0%	As required	No	No	Chapter 4 Section 3
PREVENTATIVE						
Cleaning	Not Applicable	0%	Twice per calendar year	No	No	Chapter 4 Section 3
Fluoride Treatment	Not Applicable	0%	Twice per calendar year for dependents under the age of 19	No	No	Chapter 4 Section 3
Sealants	Not Applicable	0%	For children under age 19 ,once every 24 months on unrestored permanent molars	No	No	Chapter 4 Section 3
Space Maintainers	Not Applicable	0%	For children under age 19, once every 60 months for lost deciduous (baby) teeth	No	No	Chapter 4 Section 3
MINOR RESTORATIVE						
Amalgam (silver) fillings	No	0%	Composite (white) fillings on front teeth only. For composite fillings on back teeth, the plan pays up to what would have been paid for an amalgam filling. Patient is responsible for the balance up to the dentist's charge.	No	No	Chapter 4 Section 3
Repairs to existing partial or complete dentures	No	0%	Once per calendar year	No	No	Chapter 4 Section 3
Recementing crowns or bridges	No	0%	Once every 60 months	No	No	Chapter 4 Section 3

PROCEDURE	SUBJECT TO DEDUCTIBLE?	WHAT IS MY CO-INSURANCE?	FREQUENCY/LIMITATIONS*	IS PRIOR AUTHORIZATION REQUIRED?	IS PRE-TREATMENT ESTIMATE RECOMMENDED?	WHERE CAN I FIND MORE DETAILS?
Rebasing or relining of partial or complete dentures	No	0%	Once every 60 months	No	No	Chapter 4 Section 3
MAJOR RESTORATIVE						
Crowns, build ups, posts, and cores	No	50%	Covered over natural teeth when teeth cannot be resorted with regular fillings. Replacement limited to once every 60 months.	No	Yes	Chapter 4 Section 3
ENDODONTICS						
Root canal therapy	No	0%	One procedure per tooth per lifetime.	No	No	Chapter 4 Section 3
PERIDONTICS						
Periodontal maintenance following active therapy	No	50%	Twice per calendar year	No	No	Chapter 4 Section 3
Root planing and scaling	No	50%	Once per quadrant every 24 months	No	Yes	Chapter 4 Section 3
Osseous (bone) surgery	No	50%	Once per quadrant every 36 months (bone grafts are not covered)	No	Yes	Chapter 4 Section 3
Gingivectomies	No	50%	Once per site every 36 months	No	Yes	Chapter 4 Section 3
Soft tissue grafts	No	50%	Once per site every 60 months	No	Yes	Chapter 4 Section 3
Crown lengthening	No	50%	Once per site every 60 months	No	Yes	Chapter 4 Section 3
PROSTHODONTICS						
Bridges and crowns over implants	No	50%	Replacement limited to once every 60 months	No	Yes	Chapter 4 Section 3

PROCEDURE	SUBJECT TO DEDUCTIBLE?	WHAT IS MY CO-INSURANCE?	FREQUENCY/LIMITATIONS*	IS PRIOR AUTHORIZATION REQUIRED?	IS PRE-TREATMENT ESTIMATE RECOMMENDED?	WHERE CAN I FIND MORE DETAILS?
Partial and complete dentures	No	50%	Replacement limited to once every 60 months	No	Yes	Chapter 4 Section 3
Surgical placement of endosteal implant and abutment	No	50%	Once per tooth per lifetime	No	Yes	Chapter 4 Section 3
EXTRACTIONS AND ORAL SURGERY						
Extractions and other routine oral surgery when not covered by a patient's medical plan	No	0%		No	No	Chapter 4 Section 3
ORTHODONTICS						
Medically necessary braces and related services	No	50%	For dependents under the age of 19 **Requires prior authorization.** No payment will be made if not obtained. Covered only when medically necessary. Patient must have severe and handicapping malocclusion as defined by our guidelines. Once per lifetime.	Yes	No	Chapter 4 Section 3
OTHER SERVICES						

PROCEDURE	SUBJECT TO DEDUCTIBLE?	WHAT IS MY CO-INSURANCE?	FREQUENCY/LIMITATIONS*	IS PRIOR AUTHORIZATION REQUIRED?	IS PRE-TREATMENT ESTIMATE RECOMMENDED?	WHERE CAN I FIND MORE DETAILS?
Palliative treatment (minor procedures necessary to relieve acute pain)	No	0%	Twice per calendar year	No	No	Chapter 4 Section 3
General anesthesia or intravenous (I.V.) sedation for certain complex surgical procedures	No	0%		No	No	Chapter 4 Section 3
Occlusal Guards	Yes	50%	Replacement limited to once every 12 months. Not covered when used as an athletic mouth guard.	No	Yes	Chapter 4 Section 3
Dependent children are covered under these benefits up until the end of the month that they turn age 19.						

CHAPTER 2 GETTING STARTED AS A MEMBER

Section 1 INTRODUCTION

Welcome to Neighborhood!

We are pleased that you chose us. We want to make sure you understand the information in this Certificate of Coverage. In addition, we want you to be satisfied with the services you receive as a Neighborhood member.

⇒ For any questions, please call Neighborhood Member Services at 1-855-321-9244. You may also visit us online at www.nhpri.org.

Section 1.1 Being Enrolled in a Neighborhood HealthSource RI Plan

Neighborhood offers a plan known as a Health Maintenance Organization (HMO). (This is only available through Healthsource RI.) This means that Neighborhood arranges for your health care through a network of contracted health care providers and facilities.

⇒ You will need to choose a **primary care provider** (PCP). If you do not choose a PCP, Neighborhood will choose one for you. Your PCP will be responsible for managing your care.You may change your PCP at any time to another provider in Neighborhood's network. For more information, please see Chapter 3.

Section 1.2 About the Certificate of Coverage Booklet

This **Certificate of Coverage** booklet tells you how to get your health plan benefits covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan. This Certificate of Coverage is also referred to as an "agreement" in this document.

When this Certificate of Coverage says "we," "us," or "our," it means Neighborhood. When it says "plan" or "our plan," it means Neighborhood. The words "coverage" and "covered services" refer to the medical care and services available to you as a member of Neighborhood.

Section 1.3 Being a Member of Neighborhood

Please take time to read this booklet. It is important that you know what covered services are available to you. It is also good to know the rules of the plan. Please see Chapter 5 for information on your rights and responsibilities. For more information, call Neighborhood Member Services at 1-855-321-9244.

CHAPTER 2 GETTING STARTED AS A MEMBER

Section 1.4 Legal Information About the Certificate of Coverage

This Certificate of Coverage is part of our agreement with you about how Neighborhood covers your health care. Other parts of this agreement include your enrollment form and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are also called "riders" or "amendments."

The agreement is in effect for the time during which you are enrolled with Neighborhood.

CHAPTER 2 GETTING STARTED AS A MEMBER

SECTION 2 Eligibility Determination and Enrollment

Section 2.1 HealthSource RI

HealthSource RI is Rhode Island's Health Benefits Exchange established as part of the Patient Protection and Affordable Care Act (ACA). HealthSource RI handles all eligibility determinations for this plan. Neighborhood enrolls members once HealthSource RI has determined they are eligible for coverage by a plan offered through the HealthSource RI. For information about who is eligible to enroll, effective dates of coverage, how to add or remove family members, or how to disenroll, please visit www.healthsourceri.com or call HealthSource RI at **1-855-840-HSRI (4774)**.

Section 2.2 Definition of Dependent

Per Rhode Island General Laws, a dependent means a spouse, child under the age of twenty-six (26) years, and an unmarried child of any age who is financially dependent upon the parent and is medically determined to have a physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months.

Section 2.3 The Plan Service Area is Rhode Island

Neighborhood's Individual Market plan is available only to individuals who live in Rhode Island. To remain a member of our plan, you must reside in Rhode Island, unless you are a dependent child living away.

CHAPTER 2 GETTING STARTED AS A MEMBER

SECTION 3 Important Materials

Section 3.1 Your Member ID Card

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

- Please check your member ID card to be sure all of the information is correct.
- Use this card for all covered medical, pharmacy, pediatric dental and behavioral health services.
- If any information is wrong, call Neighborhood Member Services at 1-855-321-9244.

Identifying Yourself as a Neighborhood Member

Your Member ID card is important and it identifies you as a Neighborhood member. Please remember to:

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

Your health care provider may ask for a photo ID to confirm that you are the cardholder.

If Your Member ID is Lost, Damaged, or Stolen

If your plan member ID card is lost, damaged or stolen, call Neighborhood Member Services at **1-855-321-9244** right away and we will send you a new card.

Membership Requirement

You are eligible for benefits if you are a member when you receive care and your membership is not in a pend status.

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

Section 3.2 Provider Directory

A current **Provider Directory** is available online at www.nhpri.org. You may also request a paper copy of the directory by calling Neighborhood Member Services at **1-855-321-9244**.

Search the online directory to find all of the PCPs, specialty providers, behavioral health providers, hospitals, and urgent centers that participate in our network. Both Neighborhood Member Services and the website can give you the most up-to-date information about changes in our network providers.

Network Providers

Network providers are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing required of members as payment in full. We have arranged for these providers to deliver covered services to members in our plan when your membership is in good standing.

It is important to know which providers are included in our network. You must use network providers to get your medical care and services when you are a member of our plan. The only exceptions are for emergency care and urgently needed care when network providers are unavailable, most often because you are out of the plan area. In some cases, Neighborhood may authorize use of out-of-network providers.

⇒ See Chapter 3 for more information about emergency, out-of-network, and out-of-area coverage.

If you do not have your copy of the provider directory, you can request a copy from Neighborhood Member Services at **1-855-321-9244**. You may also ask Neighborhood Member Services for more information about our network providers, including their qualifications.

Neighborhood's Provider Directory is also available online at www.nhpri.org.

CHAPTER 2 GETTING STARTED AS A MEMBER

SECTION 4 Keep Your Membership Record Current

Your **membership record** has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage, including your primary care provider (PCP). Your medical care providers (including doctors, hospitals, and other providers in the plan's network) need to have correct information about you. Your membership record lets providers understand what services are covered by your plan and the correct cost-sharing amounts for you. For this reason, it is very important that you help us keep your information up to date.

Neighborhood Needs to Know

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

⇒ If any of this information changes, please let us know by calling Neighborhood Member Services at 1- 855-321-9244.

SECTION 5 Keeping Your Personal Health Information Safe

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

⇒ For more information about how we protect your personal health information, see Chapter 5.

CHAPTER 3 Getting Care and Medicine

This chapter explains how to use the plan to get your medical care covered. You will find meanings of terms and rules to follow to get covered services.

⇒ For information on medical care and prescription drug coverage, see **Chapter 4, Covered Medical and Prescription Drug Benefits.**

Section 1.1 Network Providers and Covered Services

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

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term providers also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network generally bill us directly for care they give you. When you see a network provider, you usually pay only your share of the cost for their services.
- **Covered services** include all the medical care, health care services, medications, supplies, and equipment that are covered by our plan. For a list of covered services, see Chapter 4.

Section 1.2 Basic Rules for Getting Medical Care Covered

Your plan will generally cover your medical care as long as:

- The care you receive is a covered service included in the plan's **Medical and Prescription Drug Benefits** (see Chapter 4).
- The care you receive is deemed **medically necessary**. This means that the services, supplies, or drugs needed for the prevention, diagnosis, or treatment of your medical condition, meet accepted standards of medical practice.
- You have a network PCP who is providing and overseeing your care. As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter). If you do not choose a PCP, Neighborhood will assign one for you. You may change your assigned PCP to another PCP within Neighborhood's network at any time.

Referrals

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

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

You must receive your care from a network provider. In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. Here are two exceptions:

1. The plan covers emergency care or urgently needed care that you get from an out-of-network provider. Neighborhood will pay a reasonable charge for these services. You may be billed for any remaining charges. For more information about this, and to see what emergency or urgently needed care means, see Section 3 in this chapter.
2. If you need medical care that our plan is required to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. A **preauthorization** must be obtained from Neighborhood prior to seeking care. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out of network provider, or about how to initiate a preauthorization to see an out-of-network provider, see Section 2.4 in this chapter.

Section 1.3 Preauthorization

Preauthorization is required for certain covered services. Services that require preauthorization are noted in **Chapter 1, Summary of Medical and Prescription Drug Benefits**.

Neighborhood has a special team of nurses and clinical staff. This team reviews requests for hospital admissions and other treatments. The process is called **utilization management** (UM). Neighborhood's UM decisions are based on what is right for our members and what is covered. Neighborhood does not reward anyone who makes UM decisions with money or other incentives for denying or limiting services to members. Neighborhood does not give financial rewards for UM decisions that result in fewer services or less care. If you have questions about how Neighborhood makes care decisions, please contact Neighborhood Members Service at **1-855-321-9244**.

If a preauthorization is required, Neighborhood will make a decision as quickly as your health condition might require, but no later than 15 calendar days from the receipt of the request. This timeframe may be extended by 15 calendar days if you request it or Neighborhood finds there is a need for more information and documents (for example medical evidence) and the delay is in your best interest.

Your network provider is responsible for getting preauthorization for in-network covered services. If your provider determines you need care from an out-of-network provider, your provider must request approval from Neighborhood prior to scheduling an appointment or receiving covered services. Call Neighborhood Member Services at **1-855-321-9244**. Neighborhood Medical Management will review your request for services.

If your provider determines you need an out-of-network provider, your provider must request approval from Neighborhood prior to scheduling an appointment or receiving services.

Fast (Expedited) Preauthorization Review

You may request a fast preauthorization review. Neighborhood will rush the request based on either of the following conditions:

- We find that applying the standard time for making a determination could hurt your health, life, or ability to recover.
- Your PCP lets you know either spoken or in writing, that applying the standard time for making a determination could seriously jeopardize your life or ability to regain maximum function.
- Neighborhood will make a decision as expeditiously as your health condition might require, but no later than 72 hours after receipt of the request. This timeframe may be extended by 15 calendar days if you request it or Neighborhood finds there is a need for additional information and documents (for example medical evidence) and the delay is in your best interest.

Behavioral Health Preauthorization

Behavioral has a special team of nurses and clinical staff. This team reviews requests for hospital admissions and other treatments. The process is called **utilization management** (UM). Behavioral UM decisions are based on what is right for our members and what is covered. Behavioral does not reward anyone who makes UM decisions with money or other incentives for denying or limiting services to members. Behavioral does not give financial rewards for UM decisions that result in fewer services or less care. If you have questions about how the behavioral team makes care decisions, please contact Behavioral Members Service at 1-833-470-0578.

If a preauthorization is required, behavioral health will make a decision as quickly as your health condition might require, but no later than 15 calendar days from the receipt of the request. This timeframe may be extended by 15 calendar days if you request it or the behavioral team finds there is a need for more information and documents (for example medical evidence) and the delay is in your best interest.

Your network provider is responsible for getting preauthorization for in-network covered services. If your provider determines you need care from an out-of-network provider, your provider must request approval from behavioral prior to scheduling an appointment or receiving covered services. Call Behavioral Member Services at 1-833-470-0578 Medical Management will review your request for services.

If your provider determines you need an out-of-network provider, your provider must request approval from behavioral prior to scheduling an appointment or receiving services.

Behavioral Health Fast (Expedited) Preauthorization Review

You may request a fast preauthorization review. Behavioral Health will rush the request based on either of the following conditions:

- We find that applying the standard time for making a determination could hurt your health, life, or ability to recover; or
- Your provider lets you know either spoken or in writing, that applying the standard time for making a determination could seriously jeopardize your life or ability to regain maximum function.
- Behavioral Health will make a decision as expeditiously as your health condition might require, but no later than 72 hours after receipt of the request. This timeframe may be extended by 15 calendar days if you request it or the behavioral team finds there is a need for additional information and documents (for example medical evidence) and the delay is in your best interest.

Formulary Prescription Drug Preauthorization

Prescription drugs for which preauthorization is required are marked with "[PA]" on the list of covered drugs on Neighborhood's website at www.nhpri.org.

If your prescribing physician has questions, ask them to call Neighborhood Member Services at 1-855-321-9244.. To see if a prescription drug requires preauthorization, call Neighborhood Member Services or visit our website at www.nhpri.org. Additional limitations such as Step Therapy and Quantity Limits may also require you or your prescriber to initiate a request.

Our pharmacist team will review preauthorization requests within 14 calendar days from the date when the request is received with complete information. If the preauthorization request is denied, (we say "no") we send you written notification within 14 calendar days from the date when the request is received. If the preauthorization is approved (we say "yes"), we will notify your prescriber and pharmacist via fax.

You may request a fast review if the circumstances are an emergency. Due to the urgent nature of a fast review, your prescribing provider must fax the completed form to 1-866-423-0945. The provider can also submit a form through the PA portal at https://info.caremark.com/epa. If we receive a fast preauthorization review, we will respond to you with a determination within 72 hours following receipt of the completed request.

Non-Formulary Prescription Drug Preauthorization Process

If you or your physician finds that your prescription drug is not on Neighborhood's formulary, you can request that Neighborhood will cover this prescription. Approvals of non-formulary medications require documentation from your prescriber that you have tried and failed the formulary alternatives or that the alternatives are not appropriate for you and/or your condition.

Your prescribing physician must fax the completed form to 1-866-423-0945. The provider can also submit a form through the PA portal at https://info.caremark.com/epa.

Neighborhood will notify you and your prescribing physician of our decision within 72 hours or 24 hours if expedited.

If the request is approved, the approval will include the name of the approved drug and the duration of the prior authorization both standard exceptions and expedited reviews.

Non-formulary approved drugs may be subject to deductible.

If your prescriber writes for a prescription and there is a generic available but you want the Brand name product, you will be responsible for the tier cost sharing amount as well as the cost difference between the brand name drug and the generic drug.

In the event that your request is denied, please see Chapter 6 Section 5 of the Certificate of Coverage for explanation of the External Appeals Process.

Pediatric Dental Prior Authorization

Prior authorization is required for medically necessary orthodontic treatment. Medically necessary orthodontics is covered only for members under age 19. The treatment must meet the criteria set forth by Delta Dental. No payment will be made if prior authorization is not obtained.

After your dentist sends a request for authorization, Delta Dental will review the treatment plan. After reviewing the treatment plan, Delta Dental will tell you and your dentist what the estimated payment will be for those services.

NOTE: Estimates are based on available benefits. The patient must be a Delta Dental member at the time the service is done. The estimate shows what money is available at the time the estimate is done. Estimates can change because benefits may no longer be available on the date the service is done. For example, you lose coverage before the service is done.

NOTE: If the dependent child qualifies for medically necessary orthodontic treatment, Delta Dental will make periodic payments for covered orthodontic services spread over the expected course of the treatment. If the dependent child is already in active treatment and meets the medically necessary criteria when he/she becomes eligible for these services, Delta Dental will prorate payments for the remaining treatment. If coverage ends during active treatment, payments will stop as of the date the coverage ended regardless of whether or not the treatment is complete.

SECTION 2 Getting Medical Care from Plan Providers

Section 2.1 Having a Primary Care Provider

What is a Primary Care Provider (PCP)?

Your main provider is called your **primary care provider** or **PCP**. You must choose a PCP when you enroll with Neighborhood. Your PCP's name, office name, and phone number will be on your Neighborhood member ID card.

Neighborhood recognizes the important role of your PCP in administering and coordinating your medical care. Your PCP will help you make decisions when you have a medical condition, provide annual checkups, vaccinations and other visits, coordinate care with specialists or other providers, order prescriptions or tests for you and answer questions you have about your health care.

Neighborhood will automatically assign you a PCP when you enroll with Neighborhood. You do not have to keep the assigned PCP. You can change your PCP at any time to another provider in our network by calling Neighborhood Member Services at 1-855-321-9244.

Several health services are only covered when rendered by your PCP that is on file with Neighborhood or a covering practitioner. These services include pediatric preventive care visits (including routine visits, well-child check-ups, and sick visits), pediatric development, and autism screenings, , adult annual preventive care visits, well care in a provider's office, and most immunizations and vaccines.

If you need to change your PCP, it is important that you do so before you go to an appointment with your provider.

⇒ If PCP services are provided by another provider that is not your designated PCP or covering practitioner, these services will not be covered. The only exception is if you notify Neighborhood within five days of receiving the services and choose to switch to this provider as your PCP.

Some vaccinations can be provided by any provider. These include influenza (flu) vaccines, diphtheria, tetanus and pertussis vaccines, and rabies vaccines.

You may change your assigned PCP to another PCP within Neighborhood's network at any time.

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

What Does Your PCP Do For You?

- Help you decide what to do when you or your child has a medical problem
- Provide routine care
- Give you annual checkups, vaccinations (shots) and see you for other visits
- Help with your health care services and visits to other providers
- Order prescriptions or tests for you
- Give advice and answer your health care questions

Who Can Be Your PCP?

- **Family medicine doctor**: A family doctor treats patients of all ages. A family doctor provides preventive care (immunizations and check-ups), care for acute and chronic illnesses (such as asthma and diabetes), and health education. Some family doctors also take care of pre-natal patients and deliver babies.
- **Internal medicine doctor**: Internal medicine doctors diagnose and treat the diseases that affect the body's organs or the body as a whole. A doctor who practices internal medicine is also sometimes called an internist. Internal medicine doctors care for adult patients.
- **Pediatrician**: A pediatrician provides care to babies, children, and teenagers.
- **Nurse practitioner**: An advanced practice nurse who is qualified to conduct physical examinations, select plans of treatment, order appropriate laboratory tests/procedures, prescribe medications, coordinate consultations and referrals, and provide health education.
- **Obstetrician/Gynecologist (OB/GYN)**: A doctor who specializes in the care of women. This includes pregnant women, women's reproductive organs, breasts, and sexual function. An OB-GYN may also offer primary care services.
- **Physician Assistant (PA)**: A licensed practitioner who has graduated from a PA program and is qualified to conduct physical examinations, select plans of treatment, order appropriate laboratory tests/procedures, prescribe medication, coordinate consultation and referrals, and provide health education. PA must practice under supervision of a doctor.

How Do You Choose a PCP?

You will need to choose a PCP from the provider directory.

The provider directory is also available online at www.nhpri.org. Here you will find all of the primary care providers, specialty care providers, behavioral health providers, hospitals and urgent centers that participate in the network along with their office and telephone numbers. Our Provider Directory will tell you where the provider's office is located, what languages the office speaks, and what hours the office is open.

If you do not choose a PCP, Neighborhood will assign one. You may change your PCP to another network provider at any time.

When choosing a PCP, consider the following:

- The office is close to your home
- Recommended by a friend
- If you need help choosing a PCP, call Neighborhood Member Services for help. We will help you find a provider that is right for you.

You must let us know as soon as you have chosen a PCP.

One you have chosen your PCP, please contact your new PCP and identify yourself as a new Neighborhood member.

⇒ If you are switching to a new PCP:

- Please ask your former PCP to transfer your medical records to your new PCP
- Make an appointment for a check-up or to meet your PCP

Can You Change to a New PCP?

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

For a list of all primary care providers in the Neighborhood Network, visit our website at www.nhpri.org. You can also request a copy of this information by calling Neighborhood Member Services at 1-855-321-9244.

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

What Happens if Your PCP Leaves the Neighborhood Network?

If your PCP leaves the Neighborhood network, we will send you a letter. You can choose another PCP from the Neighborhood network or you will be assigned to one near your home. Please call Neighborhood Member Services at **1-855-321-9244** if you need help choosing a new PCP.

Section 2.2 Types of Medical Care that Do Not Need a Referral

A **referral** is when your PCP sends you to another physician for a specific problem. A **self-referral** is when you make an appointment at a specialty care office without talking with your PCP first. If you self-refer to a specialist's office, choose a provider who is in Neighborhood's provider network. Make sure you tell your PCP about the visit.

What Types of Providers Can You See Without Getting Approval in Advance from your PCP or from Neighborhood?

- Emergency services
    - See Chapter 3 Section 3.1
- Urgent care services
    - See Chapter 3 Section 3.2
- Obstetric (pregnancy)/gynecological (women's care)
    - Including routine visits, exams and medically necessary follow-up care and services
- Family planning, counseling, or birth control visits
- Pediatric Care (for members age 18 and under) routine eye exam (every year)
- Childbirth education and parenting classes
- Smoking cessation programs to help you quit
- Sexually transmitted disease (STD) treatment through the Rhode Island Department of Health

⇒ If you go to emergency room and are admitted as an inpatient, you or someone acting for you should call your PCP and the hospital is required to notify Neighborhood's Utilization Management Department within 3 business days of the day of admission to the hospital.

Section 2.3 Getting Care from Specialists and Other Network Providers

A specialty care provider, or specialist, is a provider who cares for a specific part of the body or for a specific disease. Specialty care providers have extra training or education about that area of the body or that disease. Your PCP is responsible for your regular care and checkups. He or she may help you see a specialist when you need one.

What Types of Providers are Considered Specialists?

Specialists include but are not limited to:

- **Cardiologist:** A doctor who treats the heart.

- **Endocrinologist**: A doctor who treats glands, for example, diabetes or thyroid disorders.
- **Oncologist**: A doctor who cares for patients with cancer.
- **Ophthalmologist**: A doctor who treats diseases of the eye.
- **Optometrist**: A doctor who provides eye care services.
- **Orthopedist**: A doctor who cares for patients with certain bone, joint or muscle conditions.
- **Podiatrist**: A doctor who cares for feet.

Do You Need a Referral to See a Specialist?

Your PCP or other may decide you should see a specialist. You may seek specialty care without a referral from your PCP; Neighborhood encourages but does not require a referral for Specialty Care. He or she will give you a referral. A **referral** means your provider recommends this specialist to diagnose and treat your condition. If given a referral, your provider will contact the specialist and let that office know you will be scheduling an appointment. Make sure you give your provider enough time to call the specialist before you make an appointment.

What if Your Specialist Leaves the Plan Network?

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

In special cases, Neighborhood will temporarily allow you to still get services and care from your PCP or specialty care provider even if she or he leaves our provider network. Some special cases might be if you are being treated for an ongoing condition or if you are pregnant. This is because your relationship with your provider is important. We will work with you and your provider to ensure a safe and comfortable transition of your health care to another provider. Please call Neighborhood Member Services at **1-855-321-9244** if your provider decides to leave our network and you need to continue to seeing him or her for a while.

Section 2.4 Getting Care from Out-of-Network Providers

Sometimes you may need to receive services from a provider who is not in Neighborhood's network. This is called getting care from an **out-of-network** provider. This may happen because you are experiencing an emergency and are not in Rhode Island. It may also happen because a specialist your PCP wants you to see is not in neighborhood's network.

What if You are Outside of Rhode Island?

You might need health care services when you are outside of Rhode Island. This means you are too far away to receive care from a provider or hospital in Neighborhood's network.

⇒ **Emergency services are always covered when you are outside of Rhode Island or the United States.** If you are experiencing an emergency, call 911 immediately or visit the nearest emergency room. Call your primary care provider when you return home to tell them what happened. If you received a bill for emergency services you received out of area, send it to Neighborhood Member Services.

Neighborhood complies with reimbursement for out of network emergency services in accordance with RIGL 27-18-76.

All other covered health care services, care and services provided out-of-network or outside of Rhode Island need to be approved by Neighborhood by first calling Neighborhood Member Services at 1-855-321-9244, Behavioral Health Member Services at 1-833-470-0578, or Delta Dental Customer Service at 1-800-843-3582.

What if a Provider is Not in Neighborhood's Network?

Sometimes you may need care from a local provider who is not in Neighborhood's provider network. This provider is **out of network**. To see an out of network provider, you need approval from Neighborhood before you make the appointment. To do this call Neighborhood Member Services at 1-855-321-9244. If you do not receive approval to see an out of network provider, you will be responsible for the cost of services.

What Do You Need to Do to Receive Approval to See an Out-Of-Network Provider?

Requests for services for non-emergency care from providers who are not in our network are considered if one of the following are met:

- The services requested are not available in Neighborhood's network.
- Providers with the same expertise are not available in Neighborhood's network.
- You are getting treatment for an acute medical condition, a chronic condition, or if you are in your second or third trimester of pregnancy, and your provider leaves the Neighborhood network.
- You are getting follow up care from emergency services.
- You have an ongoing relationship with a primary care or specialty care provider.

Neighborhood's Medical Management team will make a decision within 15 calendar days from when the request for an out-of-network service is received. If more information is

needed to help Neighborhood make a care decision, you will be notified that the decision timeframe has been extended. Requests for out-of-network services that are urgent are responded to within 72 hours. If approved, you may still be responsible for paying a portion of the cost of your visit or may be balanced bill, see section 5.1.

How Do I Receive a Fast Preauthorization?

You may request a **fast preauthorization** review for out-of-network services. Neighborhood will rush the request based on either of the following conditions:

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

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

What if You Receive Services that are not urgent or emergent from an Out-of-Network Provider Without Approval?

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

SECTION 3 Getting Emergency or Urgently Needed Care

Section 3.1 Getting Care for an Emergency

Neighborhood covers all medical emergencies. An **emergency** is a situation that is life threatening, involves severe pain, or can cause serious harm to your body or health if you do not receive treatment right away.

Examples of some types of emergencies are:

- Broken bones
- Poisoning or swallowing a dangerous substance
- Drug overdose
- Very bad pain or pressure
- Bleeding that will not stop
- Severe trouble breathing
- Change in level of consciousness
- Bad head injury
- Seizures (or a change in pattern of seizures)
- Complications of pregnancy such as persistent bleeding or severe pain
- Thoughts of harming yourself or others.

What if You Have a Medical Emergency?

- Get help as quickly as possible.
- Call 911 for help or go to the nearest **emergency room** or hospital. Call for an ambulance if you need it.
- You do not need to get approval or a referral first from your PCP.
- The hospital does not need to be part of Neighborhood's network.

How Can I Get Emergency Medical Care?

You may get covered emergency medical care whenever you need it, from network or out-of-network providers. These services may be covered anywhere including outside of Rhode Island or the United States.. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits description in Chapter 4 of this booklet.

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

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care

is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

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

What are Post-Stabilization Services?

You may need to receive services in the hospital once your emergency condition has been cared for. These are called **post-stabilization** services or care.

What Should You Do after Getting Emergency Care?

- Call your PCP within 48 hours to tell him/ her about your emergency visit.
- Tell Neighborhood about your emergency. We need to follow up on your emergency care.
- Call Neighborhood Member Services at 1-855-321-9244.
- This call should be made within 48 hours of the emergency room or urgent care facility.

Section 3.2 Getting Urgent Care

Urgently needed care is when you fall ill and need care right away. You may get care from in-network providers. You may also get care by out-of-network providers if this is your only option.

If you or your child needs urgent care, call your PCP's office. Say you need to schedule a **sick visit**. Your provider should give you an appointment within 24 hours.

In some case, your PCP will direct you to an **urgent care center** in Neighborhood's network. Urgent care sites are helpful when you have a problem that needs to be seen that day but your provider's office cannot give you an appointment.

Here are some examples of problems that need urgent care:

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

How Do You Get Urgent Care in Rhode Island?

In most situations, if you are in Rhode Island, we will cover urgently needed care. You should get this care from a network provider when available.

For more information about urgent care centers in your community, search the Neighborhood provider directory online at www.nhpri.org or call Neighborhood Member Services at 1-855-321-9244.

How Do You Get Urgent Care Outside of Rhode Island?

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

We may not cover continued services after the urgent condition is treated and stabilized. This may happen if we determine, in working with the providers, that: (1) the member is safe for transport back into Rhode Island and (2) that transport is appropriate and cost-effective.

SECTION 4 GETTING A BILL FOR COVERED SERVICES

What if a Provider or Hospital Sends You a Bill for Covered Services?

Neighborhood will help you understand the issue. If applicable, Neighborhood will pay for the care in accordance with the rules of your plan.

To better help you, please make sure you let Neighborhood know as soon as you receive any bill by calling Member Services at 1-855-321-9244.

SECTION 5 WHEN YOU NEED US TO PAY YOU BACK

Section 5.1 When to Ask Us for Reimbursement

What if You Paid for a Covered Service?

We pay network providers directly for covered services. There are times when you may need Neighborhood to pay you back. This is called a **reimbursement**. It is your right to be paid back whenever you have paid more than your share of the cost for covered services.

If you get a bill from a provider for the full cost of medical care, please call Member Services at 1-855-321-9244 to ensure that the provider is in Neighborhood's network.

Our payments to you or the provider fulfill our responsibility under this agreement. Your benefits are personal to you and cannot be given away. We reserve the right to be reimbursed by the member for payments made due to our error.

Here a few examples of when we might need to pay you back:

- You paid a bill in full for a covered service.
- You feel you paid more than your share of the cost of service.

Note:

- Network providers should always bill Neighborhood directly. Providers should only ask you for your cost-sharing payment.
- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow in network providers to add additional extra charges called **balance billing**.
- If you ever need a prescription filled at a pharmacy out of our network contact Neighborhood Member Services at 1-855-321-9244.

Section 5.2 Sending Us a Payment Request

You need to tell us right away if you need us to pay a bill. We will review your claim and pay you back, if appropriate.

Please send the following to us:

- Your request for payment in a letter
- Any bill or documentation of payment you have made
- Subscriber's name and address
- Your member ID number
- Patient's name and age
- The name, address and telephone number of the provider who did the service
- The date of service
- A description of the service including the procedure code the provider billed you
- The charge for the service
- A statement that shows that you are or you are not enrolled for coverage under any other health insurance plan and program. If you are enrolled for other coverage, you must include the name of the other carrier(s).

Mail us your request for payment and any bills or receipts to this address:

Neighborhood Member Services
Neighborhood Health Plan of Rhode Island
910 Douglas Pike
Smithfield, RI 02917

You must contact us about your bill(s) or send your bill(s) to us within 90 days from the date of the covered service, or as soon as reasonably possible. If you do not, the bill cannot be considered for payment, unless you are deemed legally unfit. In no event, except in cases of legal incapacitation, will bills submitted after more than one year be considered for payment.

For any questions, please call Neighborhood Member Services at 1-855-321-9244.

Section 5.3 We Will Review and Determine What We Owe

When we receive your request for payment, we will let you know if we need any additional information from you.

When We Pay

If we decide that the medical care is covered and you followed all the rules for getting the care, we will pay for our share of the cost.

- If you have already paid for the service: we will mail to you a reimbursement for our share of the cost of the service.

- If you have not yet paid for the service: we will mail the payment for our share of the cost of the covered service directly to the provider.

When We Do Not Pay

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

Section 5.4 What Is A Surprise Bill and What Should You Do If You Get One

What is a surprise bill

A surprise bill, also known as a 'silent' bill, is a bill you receive for covered services performed by a non-participating (out-of-network) health care provider in the following circumstances:

1. The out-of-network provider performs services at a participating (network) hospital or ambulatory surgery center and:
    a. A network doctor is not available at the time the health care service was performed; or
    b. An out-of-network provider performs services without your knowledge.
2. A network provider refers you to an out-of-network provider without your written consent. For example, when during your office visit a network doctor brings in an out-of-network provider or sends bloodwork to an out-of-network laboratory without your written consent.

A surprise bill does not include a bill for health care services when you choose to see an out-of-network provider.

What Should You Do If You Get a Surprise Bill

If you receive a bill from an out-of-network provider and believe it is a surprise bill, call the member services at 1-855-321-9244. We may request that you submit additional information needed to determine whether it is a surprise bill. If Neighborhood determines that you received a surprise bill, we will attempt to negotiate with the provider to pay the claim. You will be responsible for any associated cost-sharing of the claim.

SECTION 6 YOU MUST PAY FOR ANY SERVICES NOT COVERED

What if You Get a Service that is Not Covered by Your Plan?

Neighborhood covers all medical services that are medically necessary and follow the rules of the plan. Find this list in the plan's Medical and Prescription Drug Benefits Description (see Chapter 4).

You are responsible for paying the full cost of services that are not covered by our plan either because they are not plan covered services or they were obtained out-of-network and were not authorized.

You have the right to ask if we will cover services you are considering. You also have the right to question our decision by filing an appeal.

SECTION 7 MAKING A COMPLAINT OR APPEAL

What if We Make a Decision You Don't Agree With?

If Neighborhood makes a decision that you do not agree with, you have the right to make a complaint or file an appeal.

⟹ Please see Chapter 6 for more information about complaints and appeals.

CHAPTER 4 COVERED MEDICAL, BEHAVIORAL HEALTH/SUBSTANCE USE AND PRESCRIPTION DRUG BENEFITS

SECTION 1 COVERED MEDICAL BENEFITS

The **medical benefits** on the following pages list the services covered by your plan. Health care services and supplies are covered services only when the requirements listed below are met. They are listed as covered services in this chapter and are consistent with applicable state or federal law. Any service not listed in this section is not covered. If your provider told you the service is not covered, then the service is not covered. If you have questions about your coverage please call member services 1-855-321-9244. A summary list of excluded services can be found in Section 3 of this chapter.

- Your covered services must be provided according to the coverage guidelines established by Neighborhood and in effect when the services or supplies are provided.
- Your services (including medical care, services, medications, supplies, and equipment) must be medically necessary. **Medically necessary** means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You get care from a **network provider**. In most cases, care you receive from an out-of-network provider will not be covered (see Chapter 3).
- Service area is the State of Rhode Island. Services can only be obtained outside of the service area in an emergency, in an urgent situation, or with prior approval.
- You have a PCP who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is call giving you a **referral** (see Chapter 3)
- Some of the services listed in the Medical Benefits section are covered only if your provider or other network provider gets approval in advance (**preauthorization**) from us. Covered services that need approval in advance are marked in the **Summary of Medical and Prescription Drug Benefits** chart in Chapter 1.
- For all preventive services, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a co-payment will apply for the care received for the existing medical condition.
- We will only pay claims that are for covered services.
- For services you receive from an out-of-network provider, your provider must get preauthorization from Neighborhood. The only exceptions are:
  - Emergencies (in or out of the service area)
  - Urgently needed care when the network is not available (generally, when you are out of the service area)

⇒ Please see Chapter 1 Summary of Medical and Prescription Drug Benefits for details on required member cost-sharing.

Section 1.1 EMERGENCY AND URGENT CARE SERVICES

Ambulance Services and Emergency Transportation

Includes ground, sea, and air ambulance transportation for emergency care.

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

Treatment in an Emergency Room (ER) Emergency care is care that is needed to steady or start treatment for an emergency. These services must be done in an emergency room or in a physician's office to be covered. Benefits include the facility charge, supplies and all professional services. You may receive emergency covered services from an out-of-network provider as explained in Chapter 3. Neighborhood will pay up to the reasonable charge.

The emergency room co-payment is waived if the emergency room visit results in hospitalization within 24 hours. A co-payment may apply if you register in an Emergency Room but leave that facility without getting care. An additional day surgery co-payment may apply if day surgery is performed.

A member should call Neighborhood within 48 hours after emergency care is received. If you are admitted as an Inpatient, we recommend that you or someone acting on your behalf, call your PCP or Neighborhood within 48 hours.

Coverage includes services for an emergency in a hospital emergency room. If your condition requires immediate or urgent care but is not an emergency, contact your provider or go to an urgent care center if available.

Urgent Care Treatment in Urgent Care Centers, Facilities, or Providers Office

Urgently needed care is when you fall ill and need care right away. You may get care by out-of-network providers as explained in Chapter 3. Coverage includes visits to an urgent care center or provider's office.

Dental Emergencies

Coverage includes medically necessary services due to acute accidental injury to sound, natural teeth. An acute accidental injury is an injury caused by unintentional or unanticipated external means, resulting in physical damage. Acute accidental injuries may include conditions requiring immediate treatment to control hemorrhage, relieve acute pain, or eliminate acute infection, pulpal death, or loss of teeth. Coverage is provided in a hospital emergency room or office setting. See Chapter 4, Section 3 for non-covered dental services.

Section 1.2 OUTPATIENT CARE AND AMBULATORY PATIENT SERVICES

Acupuncture Treatment

Coverage includes the insertion of metal needles through the skin at certain points on the body, with or without the use of herbs, an electric current, heat to the needles or skin, or both, when recommended by a medical provider for chronic low back pain, fibromyalgia, or chronic migraine.

Allergy Testing

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

Blood and Blood Services

- Blood processing
- Blood administration
- Hemophilia factor products (monoclonal and recombinant) including Anti-Inhibitor Antibodies, Anti-Inhibitor Coagulant Complexes, Factor IX, Factor VIIa, Factor VIII, Factor X, Factor XIII, Coagulation Factor XIII A-subunit, Factor VIII/VWF Complex and von Willebrand Factor require preauthorization. Intravenous and subcutaneousimmunoglobulin for treatment of severe immune disorders, certain neurological conditions, infectious conditions, and bleeding disorders (preauthorization is required for these services)

Chemotherapy

Coverage includes hospital services, provider's services, administration, supplies and devices associated with treatment planning and therapy. In accordance with State of Rhode Island General Laws § 27-18-80, orally administered anticancer medications are covered on a basis no less favorable than covered intravenously-administered or injected cancer medications. Also, see below for clinical trial coverage.

Chemotherapy is subject to prior authorization, including step therapy requriemnts. Please review Neighborhood's Exchange formulary.

Chiropractic Care

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

Clinical Trials

Coverage is provided for members with cancer or other life-threatening diseases participating in approved clinical trials, in accordance with Rhode Island General Law § 27-18-74.

Members interested in participating in an approved clinical trial must meet the following qualifications for review:

- You must be an eligible participant, based on the trial protocol
- A network Provider has determined that your participation would be appropriate
- The organization administering the treatment by means of a trial is qualified to do so
- You or your Provider provides medical and scientific information that establishes your participation is appropriate in this trial

Coverage includes routine patient costs for health-related items and services furnished in connection with participation in the approved trial to the extent of which the health-related items and services would be covered for a member not enrolled in the approved trial. If a network Provider is participating in the approved trial, then you may be required to participate in the trial through the network Provider.

Coverage does not include:

- The investigational item, device or service itself
- Items and services provided solely to satisfy data collection and analysis needs and not used in the direct clinical management of the member
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
- Lodging and transportation
- Any expenses that the approved trial covers
- Non covered items or services

An approved clinical trial means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or a life-threatening disease or condition and is described in any of the following investigation approved or funded by one or more of the following:

- The federal National Institutes of Health
- The federal Centers for Disease Control and Prevention
- The federal Agency for Health Care Research and Quality
- The federal Centers for Medicare & Medicaid Services
- A cooperative group or center of any of the entities described above or the U.S. Department of Defense or the U.S. Department of Veterans' Affairs.
- A qualified non-governmental research entity identified in the guidelines issued by the federal National Institutes of Health for center support grants.
- A study or investigation conducted by the U.S. Department of Veterans' Affairs, the U.S. Department of Defense, or the U.S. Department of Energy, if the study or investigation

has been reviewed and approved through a system of peer review that the Secretary of U.S. Department of Health and Human Services determines:

- Is comparable to the system of peer review of studies and investigations used by the federal National Institutes of Health; and
- The study or investigation is conducted under an investigational new drug application reviewed by the federal Food and Drug Administration (FDA); or
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Contraceptive Services

Coverage is provided for outpatient contraceptive services, in accordance with Rhode Island General Laws § 27-18-57. This includes consultations, procedures and medical services. These services must be related to the use of all contraceptive methods approved by the FDA.

Covered services include:

- Medical examinations
- Birth control counseling
- Consultations
- Genetic counseling
- Sterilization procedures

Covered contraceptives include:

- Cervical caps
- Implantable contraceptives (e.g., Implanon® (etonorgestrel), and levonorgestrel implants)
- Intrauterine devices (IUDs)
- Depo-Provera or its generic equivalent
- Any other medically necessary contraceptive device approved by the USFDA.

Note: We cover certain contraceptives under the Prescription Drug Benefit (See Section 2 in this chapter). Those contraceptives include oral contraceptives and diaphragms.

Non-formulary drugs that have been prior approved may be subject to cost sharing. Please review Neighborhood's online formulary directory.

Diabetes Services

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

- Insulin pumps and related supplies.
- Diabetes self-management education, including medical nutrition therapy is also covered. This coverage for self-management education and education relating to medical nutrition therapy is limited to medically necessary visits upon the diagnosis of

diabetes, where a physician diagnoses a significant change in the member's symptoms or conditions that necessitate changes in a member's self-management, or where reeducation or refresher training is needed. This education, when medically necessary and prescribed by a physician, may be provided only by the physician or, upon his or her referral to an appropriately licensed and certified health care provider and may be conducted in group settings.

- Coverage for self-management education and education relating to medical nutrition therapy may also include home visits when medically necessary.
- Medical eye examinations (dilated retinal examinations).
- Preventive foot care for members with diabetes as well as therapeutic molded shoes.

Upon the approval of the FDA, new or improved diabetes equipment and supplies will be covered when medically necessary and prescribed by a physician.

Diabetes supplies may be subject to prior authorization. Please review Neighborhood's Exchange formulary.

Diagnostic Imaging and Machine Tests

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

Durable Medical Equipment

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

- Reasonable and necessary to sustain a minimum threshold of independent daily living
- Made primarily to serve a medical purpose
- Not useful in the absence of illness or injury
- Able to withstand repeated use
- Can be used in the home

In order to be eligible for coverage, the equipment must also be the most appropriate available supply or level of service for the member in question, and must consider potential benefits and harms to member in question, it may be decided that equipment is: (1) non-medical in nature and (2) used primarily for non-medical purposes. This may occur even though that equipment has some limited medical use. In this case, the equipment will not be considered DME and will not be covered under this benefit.

Early Intervention Services

In accordance with Rhode Island General Laws § 27-18-64, preventive and primary services for a dependent child who is certified by the Executive Office of Health and Human Services (EOHHS) as eligible for early intervention services are covered in full. Early intervention services must be provided by a licensed provider designated by EOHHS as an "early

intervention provider" and who works in early intervention programs approved by Executive office of Health and Human Services

Covered services include but are not limited to:

- Evaluation and case management
- Nursing care
- Occupational therapy
- Physical therapy
- Speech and language therapy
- Nutrition
- Service plan development and review
- Assistive technology approved by Executive Office of Health and Human Services

Habilitative Services

Covered Services include:

• Physical therapy

• Occupational therapy

• Speech therapy

Hearing Services

Coverage includes:

- Hearing exam – Medically necessary hearing exams are covered
- Hearing screening – Diagnostic hearing screenings such as audiometry and tympanometry tests are covered
- Hearing aids – In accordance with Rhode Island General Law § 27-41-63, coverage for hearing aids is provided for covered members up to the maximum benefit limit listed in the Summary of Medical Benefits.

Hemodialysis Services

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

Home Health Care

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

Coverage includes:

- Home visits by a physician
- Skilled nursing care and physical therapy

- Speech therapy
- Occupational therapy
- Medical/psychiatric social work
- Nutritional consultation

Homemaker services are not covered.

Hospice

The following services are covered for members who are terminally ill. Terminally ill means having a life expectancy of 6 months or less:

- Physician services
- Nursing care provided or supervised by a registered professional nurse
- Social work services
- Volunteer services
- Counseling services
- Including bereavement counseling services for the member's family for up to one year after the member's death

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

Immunizations

We cover preventive vaccinations and immunizations in accordance with current guidelines as required by the Affordable Care Act (ACA). 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 to treat an illness or injury, only your office visit co-payment will be applied.

We cover additional immunizations only when rendered before travel. Immunizations are covered only to the extent that such immunizations are recommended for adults and children by the Centers for Disease Control and Prevention (CDC). Recommendations are subject to change by the CDC.

Immunizations outside of current ACA guidelines may be subject to cost sharing. Please review Neighborhood's online formulary directory.

Infertility Services

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

- Unable to conceive or sustain a pregnancy during a period of one year

- A presumably healthy individual
- Coverage also includes standard fertility preservation services when medically necessary medical treatment may directly or indirectly cause iatrogenic infertility to a covered person.

Procedures are covered for the diagnosis and treatment of infertility to the extent that they are used in the diagnosis or treatment of conditions other than infertility. Oral and injectable drug therapies may be used to treat infertility. These therapies are covered under your Prescription Drug Benefit.

Covered infertility procedures are covered up to eight cycles per lifetime.

Injectable, Infused, or Inhaled Medications

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

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

Medications may include, but are not limited to:

- Total parenteral nutrition therapy
- Chemotherapy
- Antibiotics

Coverage includes the components required to administer these medications. This includes but is not limited to:

- DME
- Supplies
- Pharmacy compounding
- Delivery of drugs and supplies

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

Injectable, Infused, or Inhaled Medications services may be subject to prior authorization including step therapy and place of service requirements and restrictions.

Laboratory Tests

Covered laboratory tests include but are not limited to:

- Blood tests
- Urinalysis

- Throat cultures
- Glycosylated hemoglobin (A1c) tests
- Genetic and genomic testing
- Urinary protein/microalbumin and lipid profiles
- Cystic Fibrosis testing- Coverage limited to one test per lifetime for each member.

Human leukocyte antigen testing or histocompatibility locus antigen testing

- In accordance with Rhode Island General Laws § 27-18-49, testing is covered when it is necessary to establish a member's bone marrow transplant donor suitability. Coverage includes the costs of testing for A, B or DR antigens. Testing must be performed at a facility accredited by the American Association of Blood Banks or its successors. At the time of the testing, the tested person must complete and sign an informed consent form that also authorizes use of the results of the test for participation in the National Marrow Donor Program. Coverage limited to one test per lifetime for each member.

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

Preventive laboratory tests are covered in full. Some genetic and genomic tests may require prior authorization.

Lead Screenings

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

Lyme Disease

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

Medical Technology Review

New technology, services, and treatments are evaluated by a committee of Neighborhood staff and medical professionals. After review, this committee makes recommendations about covering the new technology, services, and treatment. Requests to consider new technology or new applications of existing technology may be made by members, member's family, network providers, and Neighborhood staff on behalf of a member. Requests are researched and reviewed within 90 days. Faster review can be requested for medical emergencies.

Medical Supplies

We cover the cost of certain types of medical supplies including but not limited to:

- Ostomy, tracheostomy, catheter, and oxygen supplies
- Insulin pumps and related supplies

Nutritional Counseling

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

Outpatient Surgery at a Free-Standing Ambulatory Surgery Center or in a Physician's Office

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

Pediatric Services

Please see Section 1.5 of this chapter.

Podiatrist Services

Office visits to the podiatrist are covered.

- Corrective or orthopedic shoes and orthotics used in with footwear are only covered for the treatment of diabetes.
- The treatment of flat feet is not covered unless it is surgical.

Prevention and Early Detection Services

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

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- Immunizations urged from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings in accordance with the American Academy of Pediatric Guidelines and as required by RI General Laws Section 27-38.1.
- With respect to women, such additional preventive care and screenings as provided are covered in accordance with the guidelines established by the Patient Protection and Affordable Care Act (PPACA).
- Preventive screenings for colon and colorectal cancer including colonoscopy and sigmoidoscopy in accordance with the current American Cancer Society guidelines:

- Cologuard is covered once every 2 years for members age 45 and older

- Abdominal Aortic Aneurysm Screening – one time screening for men ages 65-75 years in accordance with USPSTF recommendation.

- Routine Pap smears including coverage for one annual screening for women age 18 and older in accordance with guidelines established by the American Cancer Society.
- Routine mammograms in accordance with guidelines established by the American Cancer Society.
- Two screening mammograms per year are covered when recommended by a physician for women who have been treated for breast cancer within the last five years or are at high risk of developing breast cancer due to genetic predisposition (BRCA gene mutation or multiple first degree relatives), high risk lesion on prior biopsy (lobular carcinoma in situ), or atypical ductal hyperplasia.
- Prostate and colorectal examinations and laboratory tests for cancer for any non-symptomatic member, in accordance with the current American Cancer Society guidelines.
- Additional services including but not limited to: annual physical (adult and pediatric), breast cancer screenings; contraceptive services and treatments, primary care for preventive service, and smoking cessation counseling services.
- Obesity screening and counseling
- Statins and Smoking Cessation Medications.
- Breastfeeding support, counseling, and supplies

Primary Care Services

Primary care services include:

- Preventive services, including annual physical exams, screenings, and immunizations
- Routine sick visit and services to treat an injury or illness.
- Routine annual gynecological exam, including any medically necessary follow-up obstetric or gynecological care based on that exam.
- House calls.

Private Duty Nursing

Private duty home care is defined as nursing care in the home that is more intensive or extensive than can be delivered in a standard home care nursing visit. Private duty home care, which may be provided by a registered nurse (RN) or by a licensed practical nurse (LPN), is utilized to deliver medically necessary care, not able to be performed in a standard home care visit. Coverage is provided on a "per hour" or "per block hours" basis.

Prosthetic and Orthotic Devices

Coverage is provided in accordance with Rhode Island General Laws § 27-18-67. Prosthetic and orthotic devices are subject to medical guidelines and may include the following:

- Artificial medical device that is used to replace a missing limb, appendage, or other external human body part including an artificial limb, hand, foot, eye, breast and larynx.
- Breast prosthetics in accordance with federal and Rhode Island General Law § 27-18-39.
- Scalp hair prosthesis or wig in accordance with Rhode Island General Law § 27-18-68 for hair loss suffered as a result of cancer treatment
- Devices, accessories, and supplies necessary for attachment and operation of a covered prosthetic or orthotic
- Repair or replacement of a covered prosthetic or orthotic when malfunction is not due to misuse, neglect, stolen device or loss of device. Replacement of a covered, working device will be considered when there is a change in medical condition.
- Orthopedic devices when prescribed for treatment of diabetes

Coverage is provided for the most appropriate model that meets the member's needs, as determined by the treating Provider. Coverage is provided up to the maximum benefit limit listed in the Summary of Medical Benefits.

Radiation Therapy

Coverage includes but is not limited to radiation oncology therapy, dosimetry services, and brachytherapy. These services may be subject to prior authorization requirements.

Rehabilitative Services and Devices

Coverage includes:

- Occupational therapy
- Physical therapy
- Respiratory or pulmonary rehabilitation services
- Speech therapy
- Cardiac rehabilitation services including:
- Treatment of noted cardiovascular disease
- Convalescent phase of the rehabilitation program following hospital discharge
- Multiple risk reduction, adjustment to illness, and therapeutic exercise

Note: Rehabilitation services must be performed by a physician or by a licensed therapy provider.

Smoking Cessation Counseling Services

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

- Are provided in accordance with current guidelines established by the United States Department of Health and Human Services
- Meet the requirements of State of Rhode Island Office of the Health Insurance Commissioner (OHIC) Regulation 230-RICR-20-30-12 and in accordance with State of State of Rhode Island General Laws § 27-18-66

Coverage is also provided for prescription and over-the-counter smoking cessation agents. See Section 2 of this chapter for more details.

Special Medical Formulas

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

Non-prescription enteral formulas are covered for home use treatment of malabsorption caused by:

- Crohn's disease
- Ulcerative colitis
- Gastroesophageal reflux
- Chronic intestinal pseudo-obstruction; and Inherited diseases of amino acids and organic acids
- Inherited Metabolic Disorder

A provider must prescribe the formula or food for these treatments.

Specialty Care Services

- Gynecology exam
  - Routine annual gynecological exam, including any medically necessary follow-up obstetric or gynecological care based on that exam.
- House calls
  - Coverage includes provider's visits rendered in your home if you have an injury or illness that prohibits you from going to your provider's office.
- Specialty Care
  - Includes services provided by a specialist.
  - Under most circumstances your provider will refer you to a specialist if medically necessary.
  - See Chapter 3, Section 2 for services not requiring a referral from your provider.

Telemedicine

Coverage is provided by means of real time, two-way electronic audio visual communications performed by a participating health care provider for the delivery of covered health care services or behavioral health care services that are medically appropriate to be provided through telemedicine.

Termination of Pregnancy

Termination of pregnancy is defined as the elective elimination of a pregnancy. Benefits may vary between groups. For information about the drug used for a medical termination of pregnancy, refer to Prescription Drug Benefit section 2.1

Treatment for Temporomandibular Joint Disorders

Includes coverage for:

- Specialist exam
- Devices
- Physical therapy
- Surgery

Vision Care for Member age 19 and over

One routine eye exam per benefit year is covered. This includes:

- Routine ophthalmologic exam with refraction for new or established patient.
- Medically necessary exams are covered.

Vision Hardware for members age 19 and over

- Eyeglass lenses (one pair of lenses is covered every benefit year) including:
  - Single vision lenses
  - Conventional (lined) bifocal lenses
  - Conventional (lined) trifocal lenses
  - Lenticular lenses
  - Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, and lenticular), fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses
  - All lenses include scratch resistant coating with no additional cost-sharing amount
  - Optional covered lenses and lens treatments:
    - Ultraviolet protective coating
    - Blended segment lenses
    - Intermediate vision lenses

        - Standard progressives
        - Premium progressives (Varilux®, etc.)
        - Photochromic glass lenses
        - Plastic photosensitive lenses (Transitions®)
        - Polarized lenses
        - Standard anti-reflective (AR) coating
        - Premium AR coating
        - Ultra AR coating
        - Hi-Index lenses
- Standard eyeglasses frames are covered once every benefit year
- Contact Lenses are covered once every benefit year in lieu of eyeglasses. Additional coverage is provided for the cost of evaluation, materials, fitting, and follow-up care.
- Contact lenses may be determined to be medically necessary in the treatment of the following conditions:
    - Keratoconus
    - Pathological myopia
    - Aphakia
    - Anisometropia
    - Aniseikonia
    - Aniridia
    - Corneal disorders
    - Post-traumatic disorders
    - Irregular astigmatism

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

Wellness Benefit

Coverage includes routine wellness exams; age and gender related health screenings such as women's wellness exams, prostate cancer screenings, mammograms, and colorectal cancer screenings; age and health-related vaccines and immunizations; patient education services including programs associated with childbirth education, parenting classes, lactation counseling, smoking cessation, nutrition counseling and classes, asthma education and diabetes education. Neighborhood also offers a number of clinical programs to learn healthy habits during pregnancy

or to help manage chronic conditions such as asthma, chronic obstructive pulmonary disease (COPD), heart failure (HF), coronary artery disease (CAD), or diabetes.

Neighborhood offers rewards and incentives for healthy behavior as well as fitness center discounts at gyms across Rhode Island. Information on eligibility for rewards can be found at https://www.nhpri.org/Rewards/Rewards-CommercialPlans.aspx.

Section 1.3 INPATIENT CARE/ HOSPITALIZATION

Hospital Services

Coverage is provided for unlimited days at general hospital or at a specialty hospital.

Covered services include:

- Anesthesia
- Diagnostic tests and lab services
- Dialysis
- Drugs
- Inpatient habilitative/rehabilitation services including:

Physical Therapy

Occupational Therapy

Speech Therapy

Respiratory or pulmonary rehabilitative services

Cardiac rehabilitative services

- Intensive care/coronary care
- Nursing care
- Physical, occupational, speech, and respiratory therapies
- Surgery
- Provider's services while hospitalized
- Radiation therapy
- Semi-private room (private room when medically necessary)

Mastectomy, Reconstructive Surgery, and Procedures

The following services are covered with no cost sharing in connection with a mastectomy, in accordance with State of Rhode Island General Laws § 27-18-39:

- Surgical procedures known as a mastectomy.
- Axillary node dissection.
- Reconstruction of the breast affected by the mastectomy.

- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications of all stages of mastectomy (including lymphedema).
- Inpatient hospital stay for a minimum of 48 hours following a surgical procedure known as a mastectomy.
- Inpatient hospital stay for a minimum of 24 hours following an axillary node dissection.

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

- Breast prostheses are covered as described under Prosthetic and Orthotic Devices in Section 1.2.

Removal of a breast implant is covered when:

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

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

Reconstructive surgery and procedures to treat a functional deformity or impairment, other than those relating to a mastectomy, are covered when the following conditions are met:

- The functional deformity is due to a previous, covered therapeutic treatment or procedure; or
- The documented functional impairment was caused by trauma, congenital anomaly or disease

Functional indications for surgical treatment do not include psychological, psychiatric or emotional conditions.

When medically necessary, some surgical procedures to treat functional impairments are covered. These procedures may include but are not limited to the following:

- Panniculectomy
- Blepharoplasty and Ptosis repair
- Gastric Bypass or Gastric Banding
- Nasal reconstruction and Septorhinoplasty
- Orthognathic surgery including Mandibular and Maxillary Osteotomy
- Reduction Mammoplasty
- Removal of Breast Implants
- Treatment of Varicose Veins

- Removal or Treatment of Proliferative Vascular Lesions or Hemangiomas

Cosmetic surgery is not covered.

Sexual reassignment/gender dysphoria treatment

Gender Dysphoria is defined as a marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning. Gender dysphoria treatment can consist of medications (hormones), surgery, and counseling Coverage Includes:

- Psychotherapy
- Laboratory testing
- Hormone Therapy-Prior authorization is required for Pharmacological and Hormonal Therapy used to delay/change physical appearance for member age 17 or younger.
- Gender Confirmation Surgical Services- Sex reassignment surgery is covered only for individuals who have documented gender dysphoria and are 18 year of age or older.

Skilled Care in a Nursing Facility

Care in a skilled nursing facility is covered if:

- Your condition needs skilled nursing services, skilled rehabilitation services or skilled nursing observation;
- The services are required on a daily basis; and
- This care can be provided only in a skilled nursing facility.

Solid Organ and Hematopoietic Stem Cell Transplants

Coverage is provided for solid organ transplants and hematopoietic stem cell transplants including heart, lung, kidney, kidney-pancreas (for members with Type 1 Diabetes only), liver, intestinal, bone marrow and stem cell for members who are the solid organ or stem cell recipients. When the recipient is a member, the following services related to the procurement of the stem cells or solid organ from the donor are covered, but only to the extent that such services are not covered by any other plan of health benefits or health care coverage:

- Evaluation and preparation of the donor
- Obtaining donated organs for the member receiving a transplant
- Donor costs including surgical intervention and recovery services related directly to donating the stem cells or solid organ to the member
- A member's donor search expenses for donors related by blood
- The member's donor search expenses for up to 10 searches for donors not related by blood
- A member's human leukocyte antigen (HLA) testing
- Transport of donated organs for the member receiving a transplant

We do not cover donor charges for a member who donates stem cells or solid organs to a non-member.

Section 1.4 Prenatal Care, Maternity Care, Delivery and Postpartum Care

Prenatal Care, Maternity Care, Delivery, and Postpartum Care

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

Laboratory tests associated with routine maternity care are covered in full.

Hospital and delivery services and newborn in hospital child care are covered. Coverage includes the services of licensed midwives for services within the licensed midwives' area of professional competence as defined by State of Rhode Island General Laws § 23-13-9 and are currently reimbursed when rendered by any other licensed health care provider. Payment for licensed midwives will be made for services provided in a licensed health care facility and in accordance with department of health rules and regulations.

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

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

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

Well Baby Care and Visits

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

Coverage of the newborn child will continue for 31 days after birth under the account of the guardian of the child. For coverage to continue beyond this 31-day period, you must enroll the child.

The effective date of a newborn child can be the date of birth of the child or the first day of the month following the birth of the child.

Inherited Metabolic Disorder- PKU

Includes:

- Screening
- Special medical formulas

Hearing Loss Screening in Newborns

See Section 1.5 Pediatric Care.

SECTION 1.5 PEDIATRIC CARE

Pediatric Primary and Preventive Care

For Pediatric care services that are required under Federal Law §156.110 (a)(10), coverage is provided for enrollees until the end of the month in which the enrollee turns 19 years of age. Pediatric preventive care coverage is provided in accordance with the American Academy of Pediatrics guidelines. All preventive care services shall also follow Neighborhood's prevention and early detection services. Covered pediatric services include:

- Preventive services
- Services to treat an injury or illness
- House calls

Pediatric Vision Care Services

- Eye exam (one routine eye exam per year). This includes:
    - Routine ophthalmologic exam with refraction for new or established patient
    - Instead of a complete exam, we will cover retinoscopy (when applicable) which includes objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Low vision services. Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for our member with low vision. Covered low vision services are in addition to Pediatric Vision Care Services and include:
    - One comprehensive low vision evaluation every 5 years.
    - Up to four follow-up visits for low vision care in any five-year period, in addition to an annual routine exam.

Pediatric Eyewear

- Eyeglass lenses (one pair of lenses is covered every benefit year) including:
    - Single vision lenses
    - Conventional (lined) bifocal lenses
    - Conventional (lined) trifocal lenses

- Lenticular lenses
- Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, and lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses
- Polycarbonate lenses are covered in full for children
- All lenses include scratch resistant coating with no additional cost-sharing amount
- Optional covered lenses and lens treatments:
  - Ultraviolet protective coating
  - Polycarbonate lenses
  - Blended segment lenses
  - Intermediate vision lenses
  - Standard progressives
  - Premium progressives (Varilux®, etc.)
  - Photochromic glass lenses
  - Plastic photosensitive lenses (Transitions®)
  - Polarized lenses
  - Standard anti-reflective (AR) coating
  - Premium AR coating
  - Ultra AR coating
  - Hi-Index lenses

- Standard eyeglasses frames are covered once every benefit year
- Contact Lenses are covered once every benefit year in lieu of eyeglasses. Additional coverage is provided for the cost of evaluation, materials, fitting, and follow-up care.
- Contact lenses may be determined to be medically necessary in the treatment of the following conditions:
  - Keratoconus
  - Pathological myopia
  - Aphakia
  - Anisometropia
  - Aniseikonia
  - Aniridia
  - Corneal disorders
  - Post-traumatic disorders

- Irregular astigmatism

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

Section 1.6 BEHAVIORAL HEALTH AND SUBSTANCE USE CARE

Neighborhood provides covered behavioral health and substance use treatment services in parity with all other covered services. There are no limitations on the number of treatment episodes, visits, or days of coverage for inpatient, intermediate or outpatient treatment, as long as the member is meeting medical necessity criteria. Services may be obtained outside of the network in an emergent/urgent situation or with prior approval. Neighborhood's provider network includes all hospital and community-based facilities.

If you receive an in-network behavioral health visit and primary care visit in the same day and in the same location, you may be eligible to pay a single co-payment for those services. Contact your provider or Neighborhood Member Services at 1-855-321-9244 to see if your providers qualify.

Covered behavioral health and substance use services are listed in this section. Services not listed in this section are not covered. If your provider told you the service is not covered, then the service is not covered. If you have questions about your coverage please call member services 1-855-321-9244.

Outpatient Behavioral Health and Substance Use Services

Services to diagnose and treat mental health and substance use disorders in an outpatient setting are covered.

Outpatient Office:

- Psychological Testing
- Transcranial Magnetic Stimulation (Prior Authorization Required)
- Electroconvulsive Therapy (ECT) (Prior Authorization Required)
- Therapy
- Medication Management
- Medication Assisted Treatment
- Applied Behavioral Analysis (ABA)

Outpatient Other Behavioral Health and Substance Use Services

- Partial Hospitalization Program (PHP) (Prior Authorization Required)
- Intensive Outpatient Program (IOP) (Prior Authorization Required)
- Enhanced Outpatient Service (EOS)
  - Home/community based clinical services provided by a team of specialized licensed therapist and case managers
- Community based Narcotic Treatment

Inpatient Behavioral Health and Substance Use Services

- Inpatient services for behavioral health disorders in a general hospital or a behavioral health hospital.
- Inpatient detoxification and treatment services in a general hospital or substance use facility
- Community Based Detox
- Substance Use Residential
- Mental Health Residential/Crisis Stabilization

SECTION 2 PRESCRIPTION DRUG BENEFITS

Section 2.1 Your Prescription Drug Benefits

How are your Prescription Drugs Covered?

Neighborhood publishes a list of all the drugs that are covered. This list is called a **formulary**. Our formulary can be found at our website at www.nhpri.org or you can call Neighborhood Member Services at 1-855-321-9244.

Drugs listed are covered only if they comply with the Neighborhood Pharmacy Management Programs explained in the next section and are:

- Used to treat an injury, illness, or pregnancy; and
- Are medically necessary.

For details on member cost-sharing for covered prescription drugs, please see Chapter 1 Summary of Medical and Prescription Drug Benefits at the beginning of this document.

Any drugs or supplies not listed in this section are not covered. If your provider told you the drug or supply is not covered, then the drug or supply is not covered. If you have questions about your coverage please call member services 1-855-321-9244.

Formulary Coverage

We cover the following under this Prescription Drug Benefit:

- Insulin, oral agents for controlling blood sugar, insulin syringes, insulin needles, insulin pens, glucometers, glucometer test strips, lancets, alcohol wipes, and additional items that are included on our list of covered drugs
- Specific oral contraceptives and diaphragms, and other hormonal contraceptives that by law require a prescription
- Fluoride for children
- In accordance with State of Rhode Island General Laws § 27-55-2, specific off-label use of FDA -approved prescription drugs used in the treatment of cancer and any disabling or life-threatening disease which have not been approved by the FDA for that indication; provided, however, that such a drug is recognized for such treatment in one of the standard reference compendia, or in the medical literature.
- Compounded prescriptions are only covered if one active ingredient requires a prescription and is covered on the formulary, Compounded medications are subject to prior authorization.
- Specific over-the-counter (OTC) drugs. Find list online at www.nhpri.org
- Specific prescription and OTC smoking cessation agents prescribed by a plan provider.
- Prescription Drugs listed on the Formulary

Specialty Drugs

Drugs that are typically high-cost agents that may be administered orally, by inhalation, implantation or injection and possess any of the following characteristics:

- Are used to treat or diagnose rare or complex diseases
- Require close clinical supervision or monitoring of side effects
- Require special handling
- Have limited access or restricted distribution channels

Certain prescription drug products may be subject to a Neighborhood Pharmacy Management Program which is described in the next section.

90 Day Order for Maintenance Drugs Neighborhood offers a 90-day order prescription for certain chronic medications. Call our member services team for more information about what prescriptions are covered and how to enroll at 1-855-321-9244.

Section 2.2 Pharmacy Management Programs

What are Pharmacy Management Programs?

Neighborhood has a set of **Pharmacy Management Programs**. These programs help to keep the medications in our Prescription Drug Benefit safe, suitable and affordable.

Pharmacy Utilization Management:

Some prescription drugs have coverage rules and limits. At times, you may have to follow certain steps before a drug can be prescribed to you. Please see examples below:

Prior Authorization: Some medications require prior approval before filling your prescription.

Step Therapy: At times, you may have to try another drug before the one that your doctor prescribed. This is called step therapy.

Quantity Limits: Some medications have limits on the amount you can receive.

To see if your prescription has any of these requirements, please visit our Pharmacy Formulary located at www.nhpri.org or call our Member Services team at 1-855-321-9244 for more information.

If you require an exception to the rule or are attempting to meet our prior authorization criteria, Neighborhood will respond to requests from your prescriber within 14 calendar days. For expedited reviews, Neighborhood will respond within 72 hours. Please see Formulary Prescription Drug Preauthorization for more information.

New-to-Market Drug Evaluation Process

Neighborhood has selected to use our PBM's (CVS Caremark) National Formulary for Exchange. As part of that decision, we utilize CVS Caremark's Pharmacy and Therapeutics' (P&T) Committee to review new-to-market drug products for safety, clinical effectiveness, and cost. The review is generally completed within the twelve-month period following the marketing launch of the drug. Following the recommendations of the P&T, new drugs may be added to the formulary. Drugs not reviewed and approved by P&T are subject to our formulary exception policy and may be covered with appropriate documentation from your prescriber.

Medication Synchronization

Neighborhood is in compliance with Rhode Island General Law 27-18-50.1 Medication Synchronization, for prescriptions that meet the requirements defined by the law.

Specialty Drugs:

A Specialty Drug is a type of prescription drug available on the formulary

that is complex and expensive. Specialty Drugs are used to treat serious and/or chronic health conditions such as rheumatoid arthritis, HIV and hepatitis C. Often times these drugs require intensive monitoring and are available through a specialty pharmacy program. The Specialty pharmacy program may require the drug be purchased through a defined specialty vendor or covered through a specific benefit (i.e. medical versus pharmacy). If such a drug is purchased through recognized specialty pharmacies, specialty tier cost-sharing will apply.

Formulary Changes
Neighborhood is in compliance with Rhode Island General Law § 27-18-50. Neighborhood provides a 30-day notice to impacted members and authorized prescribers of formulary changes. Examples of changes include higher copay tier, non-coverage, step edit requirements, or quantity limits.

Section 2.3 Non-Covered Drugs

What Drugs are Not Covered by Your Prescription Drug Benefit? A small number of drugs are not covered. Drugs not covered include:

Drugs and/or drug therapies for cosmetic purposes including but not limited to treatment of facial wrinkles, "fungal" nails not confirmed by laboratory results, hair restoration (except as an adjunct to chemotherapy, hair removal, or vitiligo).

Drugs and/or drug therapies used for the treatment of sexual and/or erectile dysfunction.

Experimental drugs and/or drug therapies, with the exception of those required by federal or Rhode Island law.

If your provider wants you to take a medication that is not on the formulary or restricted by us, they may submit a preauthorization. We will approve the request if it meets our guidelines for coverage. For more information, call Neighborhood Member Services at 1-855-321-9244.

Section 2.4 Questions

What if You Have Questions About a Prescription or Your Prescription Drug Benefit?

For all prescription drug benefit questions please visit https://www.caremark.com/wps/portal or call Neighborhood Member Services at 1-855-321-9244.

SECTION 3 PEDIATRIC DENTAL SERVICES

SECTION 3.1 Pediatric Dental Management Programs

Neighborhood provides covered pediatric dental services for members under the age of 19. Some covered services could have frequency and limitations on when the services will be paid. If your plan frequency limitations it will be shown in the Summary of Benefits.

Utilization Review Guidelines

Delta Dental's Dental Case Management area performs clinical claims reviews. These reviews help *Delta Dental* decide if the service meets *Delta Dental's* review guidelines. Analysts who review claims are registered dental *hygienists;* or, dental assistants with clinical experience. The analysts review claims. They can approve services. Only a dental consultant, who is a licensed *dentist,* can deny a claim.

Delta Dental reviews claims using written review guidelines. *Delta Dental* bases *their* guidelines on accepted standards of care in the dental profession. They are backed by statistical studies of practice patterns. They also comply with guidelines approved by the Delta Dental Plans Association. These guidelines, as well as contract limits, are the basis for review decisions. *Delta Dental* creates clinical guidelines and utilization review standards with guidance from the Dental Director; in-house dental consultants; and, a dental advisory committee. The committee is made up of *participating dentists. Delta Dental's* dental consultants and dental advisory committee study trends in dentistry; the proven value of new materials and procedures; treatment longevity; and, local and national practice patterns.

Quality Management Programs

Delta Dental strives to provide high quality products and services. *Delta Dental* does this by monitoring; identifying; and, tracking key issues over time. *Delta Dental* deals with these issues as part of *their* review of *Delta Dental's* Quality Program.

Assessment of New Dental Materials and Treatments

Delta Dental studies new dental materials and treatments. *Delta Dental* also studies how effective they are and the cost. Then, *Delta Dental* decides if *they* will cover the material or treatment.

SECTION 3.2 Limitations on Pediatric Dental Services

Some covered services have frequency limits and/or other limitations on when they will be paid. Refer to the limitations listed in Chapter 1 Section 4- Summary of Pediatric Dental Benefits.

Delta Dental and Neighborhood Health Plan of Rhode Island reserve the right to evaluate plan policies and provisions that we deem reasonable when we approve the eligibility of subscribers; and, the appropriateness of treatment plans and related charges.

SECTION 4 SERVICES NOT COVERED BY THE PLAN

This section tells you what services are **excluded**. This means that the plan does not cover these benefit or services, or if they are covered, you do not meet the medical necessity criteria to receive them. Services that are not listed as covered in Chapter 4 Section 3, are not covered. If you have questions about coverage please call member services 1-855-321-9244. If you get benefits that are not covered or without prior approval in non-emergent situation, you must pay for them yourself. You have the right to appeal a decision for non-coverage of benefits. Please see Chapter 6.

Alternative, Holistic, Naturopathic, and/or Functional Health

Alternative medicine services, supplies or procedures are not covered. Biofeedback is not covered except for the treatment of urinary incontinence. Hypnotherapy is not covered.

Circumcision

Circumcisions will not be covered if they are performed in any setting other than a hospital, day surgery, or a physician's office.

Cosmetic Services

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

- Cervicoplasty (plastic surgery on the neck or on the cervix of the uterus)
- Chemical exfoliations, peels, abrasions (or dermabrasions or planing for acne, scarring, wrinkling, sun damage, or other conditions)
- Correction of variations in normal anatomy including augmentation mammoplasty, mastopexy, and correction of congenital breast asymmetry (modifying the size, contour, and elevation of breasts)
- 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
- Excision of excess skin or subcutaneous tissue including brachioplasty (arm lift) or abdominoplasty (tummy tuck) (except Panniculectomy as described in this agreement)
- Genioplasty (reduction and addition of material to the chin)

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

Custodial Care

Custodial care, rest care, day care, or non-skilled care in any facility is not covered. This includes care in convalescent homes, nursing homes, homes for the aged, halfway houses, or other residential facilities.

Dental Care

Adult preventive and restorative services, treatments, and supplies are not covered. Routine exams, X-rays and cleanings are examples of non-covered preventive services.

Restorative services involve the repair, strengthening, or replacement of teeth due to decay, deterioration, or fracture. Tooth extractions, fillings, and implants are examples of restorative treatment that is not covered.

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

- Services done by a non-participating dentist.
- Services that are not dentally necessary and appropriate according to Delta Dental's review guidelines. Services subject to these guidelines include, but are not limited to, root canals; crowns and related services; bridges; periodontal services; orthodontics; and, oral surgery. Delta Dental will make a decision whether a service is dentally necessary based on these guidelines. A service may not be covered under these guidelines even if it was recommended by a dentist. The guidelines can be found at www.deltadentalri.com. You can have your dentist send Delta Dental a request for a pre-treatment estimate in advance of the service to see if the service meets our guidelines.
- Services received from a dental or medical department maintained by or on behalf of an employer; a mutual benefit association; labor union; trustee; or, similar person or group.
- An illness or injury that Delta Dental decides is employment-related.
- Services you would not have to pay for if you did not have this Certificate.
- Services or supplies that are experimental in terms of generally accepted dental standards.
- Services done by a dentist who is a member of your immediate family.
- Services done by someone who is not a licensed dentist or a licensed hygienist working as authorized by applicable law.
- Consultations by a specialist.
- Disorders related to the temporomandibular joints – (TMJ), including surgery.
- Services to increase the height of teeth or restore occlusion.
- Restorations needed because you grind your teeth or due to erosion, abrasion, or attrition.
- Services done mainly to change or to improve your appearance.
- Elective orthodontics.
- Medically necessary orthodontics that was not pre-approved.
- Medically necessary orthodontics that was not done by an orthodontist.
- Athletic mouth guards
- Bone grafts.
- Splinting and other services to stabilize teeth.
- Laboratory or bacteriological tests or reports.
- Temporary, complete dentures or temporary, fixed bridges or crowns.
- Prescription drugs.
- Guided tissue regeneration
- General anesthesia or intravenous sedation given by anyone other than a dentist.
- General anesthesia or intravenous sedation for non-surgical extractions, diagnostic, preventive, or minor restorative services.

Devices, Appliances, and Prosthetics

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

- Devices used specifically as safety items or to affect performance in sports-related activities
- Orthotic appliances that straighten or re-shape a body part such as foot orthotics and cranial banding
- Repair or replacement of device, appliance or prosthetic that is still under warranty
- Some types of braces, including over-the-counter orthotic braces
- Devices and procedures intended to reduce snoring. Exclusions include, but are not limited to, laser- assisted uvulopalatoplasty, somnoplasty, and snore guards
- Electric hospital grade breast pump purchases

Eyeglasses, Lenses, or Frames

Except as described in this agreement as covered, exclusions include:

- Refractive eye surgery (including radial keratotomy) for conditions that can be corrected by means other than surgery, contact lenses, or contact lens fittings.
- Deluxe frames are not covered.

Experimental or New Services, Supplies, or Medications

Except as otherwise required by federal and Rhode Island law, Neighborhood Health Plan of Rhode Island (Neighborhood) does not cover experimental or investigative treatment or drugs. This applies to medications, procedures, devices, diagnostic modalities, supplies, services, facilities, and protocols. Through a formal review process, Neighborhood will make a determination as to whether a medication, procedure, device, diagnostic modality, supply, service, facility, or protocol will not be covered because the measure is experimental or investigational. If a member disagrees, the member has the right to appeal this decision.

Home Births

Costs associated with the services provided by a doula are not covered.

Homemaker Services

These services are incidental to a person's health needs and include but are not limited to such services as making a person's bed, cleaning a person's living areas such as bedroom and bathroom, and performing other daily living tasks such as laundry and shopping.

Human Organ Transplants

Non-covered services for human organ transplants include but are not limited to:

- Experimental or Investigational transplant procedures except those required by federal or Rhode Island law
- Services or supplies related to an excluded procedure
- Services or supplies for a donor that are not directly related to the organ transplant
- Expenses for donor searches
- Services relating to collection, preservation and potential future use of umbilical cord blood
- Donor related medical or other expenses of a transplant when the recipient is not a member

Infertility Services

Infertility treatment is not covered for (except as indicated in Chapter 4 Section 1.1):

- Members who do not meet the definition of infertility
- Experimental infertility procedures
- The costs of surrogacy, including all costs incurred by a fertile woman to achieve a pregnancy as a surrogate or gestational carrier for an infertile member. These costs include, but are not limited to:
    - Costs for drugs needed for implantation, embryo transfer, and cryopreservation of embryos
    - Use of donor egg and a gestational carrier
    - Costs for maternity care if the surrogate is not a member.
    - A surrogate is a person who carries and delivers a child for another either through artificial insemination or surgical implantation of an embryo.
    - A gestational carrier is a surrogate with no biological connection to the embryo/child.
- Costs associated with donor recruitment and compensation
- Infertility services which are necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization
- Donor sperm and associated laboratory services in the absence of diagnosed male factor infertility in the partner

- Drugs for anonymous or designated egg donors that are directly related to a stimulated Assisted Reproductive Technology (ART) cycle, unless the member is the sole recipient of the donor's eggs. Preauthorization is required for these services.

Note: We may authorize short-term (less than 90 days) cryopreservation of sperm or embryos for certain medical conditions that may impact a member's future fertility. Preauthorization required for these services. Infertile member must be of the recipient of intended infertility services.

Items for Personal Care, Comfort, or Ease

This list includes:

- Television, telephone and beauty/ barber service or guest services
- Charges gained when the member, for his or her convenience, chooses to remain an inpatient beyond the discharge hour
- Supplies, equipment, and services and supplies primarily for personal comfort

Lodging

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

Network Restrictions

Services must be rendered by network providers unless it is an emergency, urgent care, or preauthorization has been received.

Services outside the United States are not covered with the exception of emergency and urgent care services.

Non-Conventional Settings

This includes any services, programs, supplies or procedures provided in a non-conventional setting are excluded. Non-conventional settings include, spas/resorts, educational, vocational, or recreational settings, Outward Bound, or wilderness, camp, or ranch programs. Non-conventional settings not listed are subject to review before approval. This is the case even if the services, programs, supplies or procedures are performed or provided by licensed providers, such as behavioral health professionals, nutritionists, nurses or physicians. Some examples of services that may be excluded if they are performed in a non-conventional setting are psychotherapy, ABA services, and nutritional counseling.

Pediatric Vision Care Services, Treatments, and Supplies Limitations

Pediatric vision care services exclude:

- Services and materials not meeting accepted standards of optometric practice

- Special lens designs or coatings other than those described as covered services
- Replacement of lost or stolen eyewear
- Non-prescription (Plano) lenses
- Two pairs of eyeglasses in lieu of bifocals
- Insurance of contact lenses

Prescription Drug Benefit Limitations

Excluded prescription drug services include:

- Compounded medications, if no active ingredients require a prescription by law
- Drugs dispensed in an amount or dosage that is higher than our set limits
- Drugs for the treatment of sexual and/or erectile dysfunction
- Experimental drugs: drugs that cannot be marketed lawfully without the approval of the FDA and such approval has not been granted at the time of their use or proposed use or such approval has been withdrawn
- Non-drug products such as therapeutic or other prosthetic devices, appliances, supports, or other non-medical products. These may be provided as described earlier in this chapter.
- Prescription and OTC homeopathic drugs
- Prescriptions filled at pharmacies other than Neighborhood network retail pharmacies, except for emergency care
- Prescription drugs once the same active ingredient or a modified version of an active ingredient is available over-the-counter. In this case, the specific medication may not be covered. For more information, call Neighborhood Member Services. You can also check our website at www.nhpri.org.
- Prescription drugs when packaged with non-prescription products
- OTC drugs/products are not covered unless they are listed on our formulary on our website at www.nhpri.org.

Reversal of Voluntary Sterilization, or OTC Contraceptive Agents

Medical or surgical procedures for reversal of voluntary sterilization or over-the-counter contraceptive agents are not covered

Services, Supplies, or Drugs

- Services, supplies, or medications required by a third party which are not otherwise medically necessary. Examples of a third party are an employer, an insurance company, a school, or a court.

- Services for which you are not legally obligated to pay, including services for which no charge would be made if you had no plan
- Services provided to a non-member, except as described in this agreement
- Care for conditions that are already covered under federal, state, or local laws. This list includes workers' compensation, no-fault auto insurance, or other government programs
- Care for conditions that state or local law requires to be treated in a public facility
- Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you
- Health services while on active military duty.
- Any additional fee a provider may charge

Sexual and/or erectile dysfunction treatment

Services and treatment related to sexual and/or erectile dysfunctions, except *medically necessary* services for treatment related to an organic condition.

Sexual reassignment/gender dysphoria treatment

Exclusions include:

- Cryopreservation, storage and thawing of reproductive tissue
- Procedures designed to enhance masculinity or femininity or to alter body contours for aesthetic reasons are considered cosmetic and are excluded unless for the treatment of gynecomastia and gender dysphoria.
- Voice Modification Surgery
- Reversal of genital surgery

Telemedicine

Exclusions include:

- Per the Telemedicine Coverage Act- services under Telemedicine does not include audio only telephone conversation, email messaging, or facsimile transmission between the provider and the member or an automated computer program that is used to diagnose or treat ocular or refractive conditions.
- Health care services that are not medically appropriate to be provided through telemedicine are excluded.

Transportation

Exclusions include, but are not limited to, transportation by chair car, wheelchair van, or taxi.

Vision Care Services for Members age 19 and older

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

Other General Exclusions

- Any provider charges for missing an appointment
- Charges for copies of your records, charts or X-rays, or any costs associated with forwarding/mailing copies of your records, charts or X-rays
- Electrolysis
- Examinations, evaluations or services for educational or developmental purposes including vocational rehabilitation and retraining services
- Exercise classes
- Office infection control charges
- Personal trainer
- Relaxation and massage therapies
- Services to treat learning disabilities, behavioral problems, and developmental delays and services to treat speech, hearing and language disorders in a school-based setting
- State or territorial taxes on services performed
- TENS units or other neuromuscular stimulators and related supplies
- Weight loss programs and clinics

CHAPTER 5 YOUR RIGHTS AND RESPONSIBILITES

SECTION 1 YOUR RIGHTS AS A MEMBER OF THE PLAN

Section 1.1 Your Rights as a Member

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

You have the right:

- To get information from us in a way that works for you. Our plan has people and translation services to answer questions from non-English speaking members. We can also give you information in Braille or other formats, if needed. Call Neighborhood Member Services at 1-855-321-9244.
- To get information about Neighborhood, its services, providers, and members' rights and responsibilities.
- To be treated with respect and dignity.
- To join with your practitioners in decision-making regarding your health care.
- To privacy of all records and communications to the extent required by law.
- To respectful, personal attention without regard to a person's race, ethnicity, national origin, religion, gender, gender identification, sexual orientation, age, behavioral health or physical disability, health status, claims experience, medical history, genetic information, protected veteran status, evidence of insurability, geographic location within the service area or any other category protected by law.
- To get a second medical opinion for medical and surgical concerns.
- To open talks of medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- To voice complaints or appeals about Neighborhood or the care from its providers.
- To suggest changes to our rights and responsibilities policies

Section 1.2 Your Right to Getting Information

As a member of Neighborhood, you have the right to get many kinds of information from us.

Information about Our Network Providers

You have the right to get information from us about the providers in our network.

- For a list of the providers in the plan's network, please see the provider directory.
- For more information, call Neighborhood Member Services or visit our website at www.nhpri.org.

In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services. If you have questions about the rules or restrictions, please call Neighborhood Member Services.

Information About Why Something is Not Covered or Has a Limit

If a medical service is not covered or has limited coverage and you want to know why, you have the right to ask us. We will reply with a written explanation. You have the right to an explanation even if the medical service was from an out-of-network provider.

If you do not agree with our decision, you have the right to ask us to review the issue again. You can ask us to change our decision by making an appeal (See Chapter 6). If you need us to pay a share of a bill, see Chapter 3.

Section 1.3 Your Right to Respect, Dignity and Privacy

Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person's race, ethnicity, national origin, religion, gender, gender identification, sexual orientation, age, behavioral health or physical disability, health status, claims experience, medical history, genetic information, protected veteran status, evidence of insurability, geographic location within the service area or any other category protected by law.

If you want more information or have concerns about discrimination or unfair treatment, please call the U.S. Department of Health and Human Services' Office for Civil Rights at 1800-368-1019 (TTY 1-800-537-7697) or your local office for civil rights.

For complaints and problems about getting care, Neighborhood Member Services can help. Call 1-855-321-9244.

Section 1.4 Your Right to Make Decisions About Your Health Care

You have the right to make decisions about your health care. You can refuse treatment or procedures. If you are unable to voice your decisions, there are documents that can help.

You have the right to make decisions about your health care. You can refuse treatment or procedures anytime. When you can no longer make health care decisions for yourself, there are documents that will help make your wishes known. These are called living wills, durable power of attorney, and advance directives.

Living Will

This explains your requests for what should happen if you become seriously ill and cannot communicate.

Durable Power of Attorney

This lets another person make health care decisions for you. You choose who this person will be. It could be your spouse, a family member, or a friend.

Advance Directives

This explains the treatment you want if you become seriously ill or injured. Advance directives can be written or spoken.

Ask your PCP about these options. You also can find related forms at the Rhode Island Department of Health's website at http://www.health.ri.gov/lifestages/death/about/endoflifedecisions/.

Section 1.5 Your Right to Privacy

Personal Health Information

Federal and state laws protect the privacy of your medical records and **personal health information (PHI)**. We protect your PHI as required by these laws. Your PHI includes the information you gave us when you enrolled in this plan. You will get a paper from us called the "Notice of Privacy Practice". This notice explains how we keep your PHI safe.

Please review the information below very carefully. It tells how your PHI may be used and shared. It also explains how you can get this information.

There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.

We have the right to share your PHI to:

- Help in your treatment by talking with providers in your plan of care to decide what is best
- Decide if a health care service is medically necessary
- Make sure we are meeting quality standards

- Help public health authorities for the purpose of controlling disease
- Help authorities as allowed by law to get reports of abuse, violence, or neglect
- Help in disaster relief efforts
- Help agencies that do health care inspections
- Help a person who may have exposed you to a communicable disease
- Report medication issues, like bad reactions, to the federal Food and Drug Administration
- Help with legal matters. In the course of any legal action, in response to a court order or in response to a subpoena, as long as you have been duly notified or attempts to notify you have been made according to law and the subpoena has not been withdrawn
- Help law enforcement authorities, as long as all applicable legal requirements are met
- Help a medical examiner, such as for identification purposes or determining the cause of death
- Stop or lower a serious threat to the health or safety of a person or the public if we believe that the information is needed
- Comply with workers' compensation laws and like programs
- Help with compliance issues
- Help in an emergency

In most cases, Neighborhood will not share your information without your written approval. If you change your mind on an approval to share information, it must be in writing.

Your Health Information Rights

You have the right to:

- Get a paper copy of this notice if you ask for it
- Ask us to limit the way we share your information, although we are not required to agree to what you ask
- Look at and get a copy of the health information we have about you, as provided by law
- Ask us to change information we have about you in our member file. You must ask us in writing and tell us why you are asking for the change, although we are not required to agree to the change

- Ask us to contact you in a different way. For example, you may ask us to contact you at work only
- Take back your approval that we share your information. However, you can only do that if the information has not been shared already
- Get a list of when we shared your information, except if it was for payment, treatment or operations, or with your approval

Our Duties

Neighborhood uses many methods to protect your oral, written and electronic health information from illegal use or disclosure.

We are required by law to:

- Keep your health information private
- Provide you with this notice and follow these rules
- Let you know if we cannot agree to limit how we share your information
- Agree to reasonable requests on how and where to contact you
- Get your written approval to share your health information for reasons other than those listed above and permitted by law

At Neighborhood, we make sure that anyone who comes in contact with your health information keeps it private. This includes providers, employees and vendors. We keep information safe by training our employees on how to do so. We also have our vendors sign contracts.

Neighborhood reserves the right to change its privacy practices. The new practices would apply to all of the health information we have, including the health information we already have about you.

What if You Have Questions About Your Rights and Privacy?

If you need help understanding this notice or you want to use any of your rights stated within this notice, please call Neighborhood Member Services at 1-855-321-9244.

If you think Neighborhood has shared your information incorrectly, you can file a complaint with us by contacting our Compliance Department. You can call 1-888-579-1551 and ask for the Privacy Official. If you prefer to send us a letter, address it to:

Compliance & Privacy Officer

Compliance Department

Neighborhood Health Plan of Rhode Island

910 Douglas Pike

Smithfield, RI 02917

You also have the right to complain to the Secretary of the United States Department of Health and Human Services. You must do so in writing.

Office for Civil Rights

United States Department of Health and Human Services

JFK Federal Building, Room 1875

Boston, MA 02203

Please ask us if you need help with filing a complaint. It will not harm or change your benefits.

If you suspect a problem, please call Neighborhood's Compliance Hotline at 1-888-579-1551.

Our ability to release information about you is regulated by law. Please see the Rhode Island Confidentiality of Health Care Communications and Information Act, §§ 5-37.3-1 et seq. of the State of Rhode Island General Laws, the Health Insurance Portability and Accountability Act Final Privacy Regulations, 45 CFR §§ 160.101 et seq., the Gramm-Leach-Bliley Financial Modernization Act, 15 USC §§ 6801-6908, and 230-RICR-20-30-7 adopted by OHIC.

Section 1.6 Your Right to a Second Opinion

As a Neighborhood member, you have the right to receive a second opinion. This means you want another provider's opinion.

If the provider you would like to see is not in our network, you will need approval from Neighborhood first. This is called a preauthorization. Preauthorization is not required when you seek a second or third opinion from a provider in our network.

For information on getting a second or third opinion, please call Neighborhood Member Services at 1-855-321-9244.

Section 1.7 Your Right to Discuss Your Treatment Option

You have the right to get full information from your providers and other health care providers when you go for medical care. Your network providers are required to explain your medical condition and your treatment choices in a way that you can understand. You also have the right to share in decisions about your health care.

Your rights help you make decisions with your providers about what treatment is best for you. You have the right to:

- Know all of your choices. This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.
- Know about the risks. You have the right to be told about any risks involved in your care. You must be told in advance if any medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.

- Say “no” and refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your provider advises you not to leave. If you refuse treatment, you accept full responsibility for what happens to your body as a result.

Learn from us if a provider has said no to care that you think you should have. To get this explanation, you will need to ask us for a coverage decision (see Chapter 6).

Section 1.8 Your Right to Make Complaints and Appeals

If you have any problems or concerns about your covered services or care, please see the information on making a complaint or appeal in Chapter 6.

Section 1.9 Your Right to Make Suggestions to Us

You can make recommendations about our policies by calling Neighborhood Member Services 1-855-321-9244.

SECTION 2 MEMBER'S RESPONSIBILITIES

You have responsibilities as a member of Neighborhood. If you have any questions, please call Neighborhood Member Services.

When you enroll in a Neighborhood plan, you agree to:

- Choose a primary care provider (PCP) from Neighborhoods network of providers. Your PCP will coordinate all of your medical care. If you do not choose a PCP, Neighborhood will assign one to you. You may change your PCP at any time by calling Neighborhood Member Services 1-855-321-9244.
- Have all of your medical care provided by or arranged by providers who participate in Neighborhood's network.
- Carry your Neighborhood member ID card with you and show it whenever you seek medical care.
- Pay network providers the deductible, co-insurance, co-payment, and the difference between the maximum benefit and our allowance (if any) that may apply to covered health care services.
- Help your providers and other providers help you by giving them information, asking questions, and following through on your care.
- Talk with your PCP about all specialty care. If you need a specialist, your PCP will work with you to make sure you get quality care.
- Call your PCP first for help if you have an urgent medical condition. If an emergency is life threatening, go immediately to the nearest Emergency Room or call 911. You (or a friend or relative) should contact your PCP the next day. Please see Chapter 3 for more details.
- Let Neighborhood know about changes to your name, home address, telephone number, marital status, number of dependents or if you have other insurance coverage.
- Pay your premiums.
- Pay the cost of all excluded services and items.

CHAPTER 6 COMPLAINTS AND APPEALS

SECTION 1 INTRODUCTION

Neighborhood wants you to have quality health care services. These services should meet your needs. They should happen in a timely and respectful manner. We are committed to solving any concerns you may have about the plan. To serve you better, Neighborhood has ways or "processes" to handle different problems.

The following sections will help you to find the correct process for your issue:

- Member Inquiry Process
- Member Complaint Process
- Internal (Neighborhood) Appeals Process (including Fast Appeals)
- External (outside of Neighborhood) Appeals Process

Authorization to Release of Medical Records

We may request a signed **Authorization to Release Medical Records** form. This form lets providers give medical information to us. It must be signed and dated by you or someone who represents you, like a family member.

If you want to have someone be your **authorized representative** it must be recorded in writing so that we know you approve. If an Authorization to Release Medical Records form is not with your complaint, Neighborhood Member Services will send you a blank form.

SECTION 2 MEMBER INQUIRY PROCESS

Section 2.1 What is an Inquiry?

An **inquiry** is when you are seeking information of a general nature about Neighborhood and its network such as:

- Plan action
- Policy
- Procedure

An inquiry is different from a complaint about services or the quality of care provided to you by a Neighborhood provider, Neighborhood employees, or a Neighborhood vendor. For these types of issues, you may file a **complaint**.

An inquiry is also different from a request that Neighborhood reconsider coverage of a service or supply we denied. For these types of issues, you may to file an **appeal**.

Section 2.2 How Do I Make an Inquiry?

How Do I Make an Inquiry?

- Call Neighborhood Member Services at 1-855-321-9244 to discuss your concern.
- We will make every effort to fix the problem.
- We will respond to the issue as soon as possible but not longer than three business days.
- If you tell us that you are not pleased with our answer or we were not able to fix your issue, you may choose to file a complaint or appeal.
- The process we use depends on the type of inquiry that you made.
- For verbal complaints, we will follow- up with a telephone call on a recorded line within 30 days.
- For written complaints or complaints about the quality of care provided to you we will follow-up in writing within 30 days.

SECTION 3 MEMBER COMPLAINT PROCESS

Section 3.1 What is a Complaint? What is a Grievance?

What is a Complaint?

A **complaint** is an oral or written expression of dissatisfaction from a member, or a member's authorized representative, to review an actual or an alleged circumstance that gives the member cause for protest, causes a disruption of care, creates a level of anxiety, or leads to dissatisfaction with the plan.

The member complaint process does not apply to requests for a review of a denial of coverage. If you are seeking such a review, please see the Section 4 of this chapter for information about member appeals.

Complaints could be about benefits, services, access to medical services, incorrect bills received or other issues. You may also file a complaint regarding the quality of care provided by a Neighborhood provider. Requests to file a complaint can be in writing or over the phone.

Examples of complaints include the following:

- Privacy issues
- Member services
- Access to care
- Cleanliness or condition of a clinic, hospital, or provider's office
- Written materials
- Quality of care

Section 3.2 How Do I File a Complaint?

Complaint Process

It is important that you contact us as soon as possible to explain your concern. Complaints may be filed either verbally (spoken) or in writing. To record your concerns exactly, you may want to put your complaint in writing.

Send written complaints to:

Grievance and Appeals Unit

Neighborhood Health Plan of Rhode Island
910 Douglas Pike Smithfield, RI 02917

Your explanation should include:

- Your name and address
- Your member ID number
- Daytime home phone number
- Details such as important dates, any applicable medical information, and provider names
- Any additional information you believe would be helpful.

If you choose to file a complaint verbally (spoken), please call Neighborhood Member Services at 1-855-321-9244. A Neighborhood Member Services Representative will document your concern and forward it to a Specialist in the Grievance and Appeals Unit.

Complaint Resolution

We have a 30-day review period from the date your complaint was received.

If additional information is required and it would be in your best interest to extend the timeframe, we may contact you to request permission to extend the timeframe for resolution by 14 calendar days. This would be done by mutual agreement between you and Neighborhood.

RIREACH (Rhode Island Insurance Resource, Education, and Assistance Consumer Helpline)

Separate from Neighborhood, you may also contact the State of Rhode Island Office of the Health Insurance Commissioner's consumer resource program, the Rhode Island Insurance Resource, Education, and Assistance Consumer Helpline (RIREACH), for assistance in resolving a compliant. RIREACH can be reached at 1-855-747-3224 or www.rireach.org.

SECTION 4 INTERNAL APPEALS PROCESS

Section 4.1 What is an Internal Appeal?

Internal Appeals

An **internal appeal** is a request for a review of an adverse benefit determination, a benefit denial, or a retroactive termination of coverage. Your appeal may be a medical appeal or an administrative appeal and the request may be initiated by you, a provider acting on your behalf, or by someone you appoint in writing to act as your legal representative.

A **medical appeal** is a request from a member or a provider to change or reconsider an adverse benefit determination/benefit denial made by Neighborhood Medical Management.

An **administrative appeal** is a request to change a decision regarding a submitted claim or other type of administrative dispute.

Adverse Benefit Determination

An **adverse benefit determination** is any of the following:

- Denial of a benefit (in whole or in part)
- Reduction of a benefit
- Termination of a benefit
- Failure to provide or make a payment (in whole or in part) for a benefit
- Denial, reduction, termination, source of injury exclusion, or other limitation on covered benefits
- A rescission of coverage, even if there is no adverse effect on any benefit

Benefit Denial

A **benefit denial** is a plan decision, made before or after you have obtained services, to deny coverage for a service, supply or drug that is specifically limited or excluded from coverage in this agreement; or a plan decision to deny coverage for a service, supply or drug because you are no longer eligible for coverage under the plan. This means you no longer meet the plan's eligibility criteria.

Retroactive Termination of Coverage

Retroactive termination of coverage is a retroactive stop or end of enrollment because of the plan's finding that you have done an act, practice or omission that constitutes fraud; or you have intentionally misrepresented a material fact with regard to the terms of the plan.

Section 4.2 When Should I File an Internal Appeal?

When to Make an Internal Appeal

Examples of situations when to use the internal appeals process include the following:

- You are not getting certain medical care you want, and you believe that this care is covered by our plan.
- Our plan will not approve the medical care your provider or other medical provider wants to give you, and you believe that this care is covered by the plan.
- You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.

The Neighborhood Grievance and Appeals Unit will coordinate a review of all of the information submitted upon appeal. That review will consider your benefits as detailed in this agreement. You are entitled to one level of internal review.

Section 4.3 How Do I File an Internal Appeal?

Internal Appeals Process

It is important that you contact us as soon as possible to explain your concern. You have 180 days from the date you were notified of the denial of services, supplies, benefit coverage, or claim payment, to file an appeal. Internal appeals may be submitted either verbally (spoken) or in writing. To record your concerns exactly, you may want to put your appeal in writing.

Send written medical and administrative appeals to:

Grievance and Appeals Unit

Neighborhood Health Plan of Rhode Island

910 Douglas Pike Smithfield, RI 02917

Your explanation should include:

- Your name and address
- Your member ID number
- Daytime home phone number
- Details such as important dates, any applicable medical information, and provider names
- Any additional information you believe would be helpful.

To file a verbal (spoken) appeal, call Neighborhood Member Services at 1-855-321-9244. A Neighborhood Member Services Representative will document your appeal and forward it to a Specialist in the Grievance and Appeals Unit.

For appeals related to behavioral health or substance use, please call1-833-470-0578 or submit a written appeal to:

Optum
Attn: Appeals
P.O. Box 30512
Salt Lake City, UT 84130-0512

For appeals related to pediatric dental, you must submit your appeal request in writing to Delta Dental of Rhode Island. For an urgent or emergency appeal request, you may call Customer Service at 1-800-843-3582. For all other appeals, send your appeal to:

Delta Dental of Rhode Island
Attn: Appeals
P.O. Box 1517
Providence, RI, 02901-1517

For further information regarding the consumer rights and appeals process, please visit www.deltadentalri.com and click on Members.

Acknowledgement from Neighborhood

We will acknowledge receipt of your appeal in writing within five (5) calendar days of getting your medical or administrative appeal.

Section 4.4 How Does the Medical Appeal Process Work?

Medical Appeal Process

We will review your medical appeal and make a decision within 30 calendar days from the date we received your appeal. We will notify you by sending you a decision letter. If the appeal is for a service you have already received, we will review your appeal and make a decision within 60 calendar days from the date we received your appeal. We will notify you by sending you a decision letter.

Internal Appeals

There is one level of internal appeal available. This appeal must be received within 180 days of an adverse benefit determination. Medical necessity determinations will be reviewed by a licensed healthcare provider with the same or similar licensure status as the ordering provider or or a licensed dentist and will not have participated in any of the prior decisions on the case.

For appeals related to behavioral health or substance use, you must call 1-833-470-0578 or submit a written appeal to:

Optum
Attn: Appeals
P.O. Box 30512
Salt Lake City, UT 84130-0512

For appeals related to pediatric dental, you must submit your appeal request in writing to Delta Dental of Rhode Island. For an urgent or emergency care request, you may call Customer Services at 1-800-843-3582. For all other appeals send your appeal to:

Delta Dental of Rhode Island

Attn: Appeals

P.O. Box 1517

Providence, RI, 02901-1517

For further information regarding the consumer rights and appeals process, please visit www.deltadentalri.com and click on Members.

Medical Appeal Response Letters

The letter you receive from Neighborhood will include identification of the specific information considered for your appeal and an explanation of the basis for the decision. The letter will include information on the steps for an external review by an External Appeals Agency, designated by Rhode Island Office of the Health Insurance Commissioner.

Administrative or Benefit Appeal Response Letters

The letter you receive from Neighborhood will include identification of the specific information considered for your appeal and an explanation of the basis for the decision. These appeals are not eligible for external appeal review.

Section 4.5 What is the Fast (Expedited) Appeal Process?

Fast Appeals

There are times when a decision needs to be made right away. Decisions made quickly are called **fast appeals** and are also known as **expedited appeals**. This can only be used for services that have not happened. Examples of when we would rush a decision are:

- An ongoing service is about to end;
- Waiting for a decision or service could harm your health

Additionally, we will expedite your appeal if a medical professional determines it involves emergency health care services. This is defined as medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition:

- Placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy
- Constituting a serious impairment to bodily functions Constituting a serious dysfunction of any bodily organ or part

How and Where to File a Fast (Expedited) Appeal

If you feel your request meets the criteria cited above, you or your attending provider should call Neighborhood Member Services at 1-855-321-9244. Neighborhood will make a decision as expeditiously as your health condition might require, but no later than 72 hours after the receipt of the request.

If your request does not meet criteria for a fast (expedited) appeal, you and your provider will be notified and your appeal will follow the standard review process.

For fast (expedited) appeals related to behavioral health or substance use, you must call 1-833-470-0578. **For fast (expedited) appeals related to pediatric dental**, can be submitted when the claim involves urgent or emergency services. You must call Customer Service at 1-800-843-3582. Delta Dental will complete a review and make a decision within 72 hours as long as Delta Dental has all the information needed to review the claim

Fast (expedited) Appeal Response Letters

The letter you receive from Neighborhood will include identification of the specific information considered for your appeal and an explanation of the basis for the decision. The letter will include information on the steps for an external review by an External Appeals Agency, designated by Rhode Island Office of the Health Insurance Commissioner.

Section 4.6 How Does the Administrative Appeals Process Work?

Administrative Appeal Process

We will make a decision on your administrative appeal within 30 calendar days of getting it. We will notify you in writing of our decision. If the appeal is for a service you have already received, we will review your appeal and make a decision within 60 calendar days from the date we received your appeal. We will notify you by sending you a decision letter.

Internal Administrative Appeals

Requests for administrative appeals must be received within 180 days of the date Neighborhood issued an Explanation of Benefits (EOB) with an adverse denial.

For appeals related to behavioral health or substance use, you must call 1-833-470-0578.

Optum
Attn: Appeals
P.O. Box 30512

Salt Lake City, UT 84130-0512

For appeals related to pediatric dental, you must submit your appeal request in writing. For an urgent or emergency care request, you may call Customer Service at 1-800-843-3582. For all other appeals send your appeal to:

Delta Dental of Rhode Island
Attn: Appeals
P.O. Box 1517

Providence, RI, 02901-1517

For further information regarding the consumer rights and appeals process, please visit www.deltadentalri.com and click on Members.

Administrative Appeal Response Letters

The letter you receive from Neighborhood will include identification of the specific information considered for your appeal and an explanation of the basis for the decision.

SECTION 5 EXTERNAL APPEAL PROCESS

Section 5.1 What is an External Review?

External Review Rhode Island Office of the Health Insurance Commissioner designates four (4) external review agencies that perform reviews of final medical necessity decisions. These agencies are not connected to Neighborhood in any way.

Please note that appeals for coverage of services excluded from coverage under your plan are not eligible for external review. This external review 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.

Section 5.2 How Do I Request an External Review?

External Review Process

To request an external review, you must send a letter to us within four (4) months of the receipt of your adverse determination letter. You must exhaust Neighborhood's internal appeal process before requesting an external review unless you specifically request a simultaneous internal and external expedited appeal. Neighborhood does not restrict the minimum dollar amount of a claim in seeking at external appeal.

Send your written external review request to:

Grievance and Appeals Unit

Neighborhood Health Plan of Rhode Island

910 Douglas Pike

Smithfield, RI 02917

In that letter, you must include any extra information that you would like the external review agency to consider.

Your Share of the Fee

Your share of the filing fee will be no greater than $25 per external review and no greater than $75 cumulatively per benefit year.

Other costs of the appeal will be paid by Neighborhood.

Within five days of receipt of your written request and your share of the fee, Neighborhood will forward the complete review file, including the criteria used in making our decision, along with the balance of the fee to the external appeal agency.

External Review Response

The external appeal agency will notify you or your provider of its external appeal decision to uphold or overturn the appeal no more than ten (10) calendar days from receipt of all the information necessary to complete the external review and not greater than forty-five (45) calendar days after the receipt of the request for external review. For appeals determined to be for an emergent health care service, the external appeal agency will complete a review and make a final determination within seventy-two (72) hours of receipt.

The external appeal agency will let you and your provider of record know the final answer of the appeal in writing.

- The external review will be based on the following:
    - The review criteria used by Neighborhood to make the internal appeal determination
    - The medical necessity for the care, treatment or service for which coverage was denied
    - The appropriateness of the service delivery for which coverage was denied.

The decision of the external appeals agency is binding. However, any person who is not satisfied by a final decision of the external appeals agency is entitled to judicial review in a court of competent jurisdiction.

If the external appeals agency overturns Neighborhood's internal appeal decision, Neighborhood will reimburse you for your share of the appeal fee within 60 days of the notice of the decision.

SECTION 6 LEGAL ACTION

If you are unhappy with the decision on your claim, and have complied with applicable state and federal law, you are entitled to seek judicial (legal) 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, external, and legal action), the member or provider may not ask for an appeal at the same level again, unless additional information that could affect such decisions can be provided.

Under state law, you may not begin court proceedings before the end of 60 days after the date you filed your claim. In no event may legal action be taken against Neighborhood later than three years from the date you were required to file the claim.

SECTION 7 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 60 days after the date you filed the 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 a provider.

CHAPTER 7 ENDING YOUR MEMBERSHIP IN THE PLAN

SECTION 1 INTRODUCTION

HealthSource RI is Rhode Island's Health Benefits Exchange established as part of the Patient Protection and Affordable Care Act (ACA). HealthSource RI handles all eligibility determinations for this plan. Neighborhood enrolls members once HealthSource RI has determined they are eligible for coverage by a plan offered through the HealthSource RI. For information about who is eligible to enroll, effective dates of coverage, how to add or remove family members, or how to disenroll, please visit www.healthsourceri.com or call HealthSource RI at **1-855-840-HSRI (4774).**

Section 1.1 Ending Your Membership in Our Plan

Ending your membership in Neighborhood plan may be voluntary (your own choice) or involuntary (not your own choice). This means:

- You might leave our plan because you have decided that you want to leave.
- There are also limited situations where you do not choose to leave, but we may end your membership. Section 3 tells you about situations when we may end your membership.
- If you are leaving our plan, your coverage through our plan will continue until your membership ends.

SECTION 2 WHEN YOU CAN END YOUR MEMBERSHIP IN OUR PLAN

If you decide to discontinue coverage, we must receive your notice to Neighborhood or HealthSource RI to end this agreement within 14 days prior to the requested date of cancellation. If we do not receive your notice prior to the requested date of cancellation, you may be responsible for paying another month's member premium. This agreement will end for a covered dependent if the dependent no longer qualifies as an eligible dependent.

An enrolled dependent's coverage ends when the subscriber's coverage ends, or when the dependent no longer meets the definition of a dependent, whichever occurs first. See Chapter 2, Section 2.3 for more information or call Neighborhood Member Services at 1855-321-9244.

SECTION 3 WHEN NEIGHBORHOOD MAY END YOUR MEMBERSHIP IN THE PLAN

Section 3.1 When We May End Your Membership in the Plan

HealthSource RI and Neighborhood may end your membership in the plan if any of the following happen:

- Failure to pay premiums or contributions in accordance with the terms of the health insurance coverage
- Failure to make timely premium payments

If you are a member who receives Advance Premium Tax Credits (APTCs) you will have a three-month grace period and HealthSource RI will provide you with advance notice that your payments are late. All claims incurred during the first month of the grace period will be paid by Neighborhood. After the first month of the grace period:

- Claims will be denied pending disposition of your membership status
- Providers will be notified that your membership is in a pended status and may or may not honor your membership at their discretion
- If HealthSource RI notifies Neighborhood that your active membership status is reinstated, all denied claims during the grace period will be paid.

If you do not make payment by the end of the grace period, HealthSource RI and Neighborhood will terminate your membership in the plan, effective as of the last day of the grace period.

If you are a member who does not receive APTCs, you will have a one-month grace period and HealthSource RI will provide you with advance notice that your payments are late. All claims incurred during the one-month grace period will be paid by Neighborhood. If you do not make payment by the end of the grace period, HealthSource RI and Neighborhood will terminate your membership in the plan, effective as of the last day of the grace period.

Except for fraud or intentional misrepresentation of material fact, we may not rescind the policy. We will not contest this policy after it has been in force for a period of two years from the later of the agreement effective date or latest reinstatement date.

Section 3.2 What to Do if You Move Out of Rhode Island

Neighborhood may end your membership in the plan if any of the following happen:

- Failure to pay premiums or contributions in accordance with the terms of the health insurance coverage
- Failure to make timely premium payments

You will have a one-month grace period and Neighborhood will provide you with advance notice that your payments are late. All claims incurred during the one-month grace period will be paid by Neighborhood. If you do not make payment by the end of the grace period Neighborhood will terminate your membership in the plan, effective as of the last day of the grace period.

Except for fraud or intentional misrepresentation of material fact, we may not rescind the policy. We will not contest this policy after it has been in force for a period of two years from the later of the agreement effective date or latest reinstatement date.

If you are a member and you move out of Rhode Island, coverage ends on the date you move. Children are not required to maintain primary residence in Rhode Island. However, care outside of Rhode Island or the United States is limited to emergency or urgent care only.

Before you move, call Neighborhood Member Services to notify us as of your move date. You may have kept a residence in Rhode Island but been out of Rhode Island for more than 90 days. If this happens, coverage ends 90 days after the date you left Rhode Island.

Section 3.3 Membership Termination for Acts of Physical or Verbal Abuse

We may terminate your coverage if you commit acts of physical or verbal abuse which:

- Are unrelated to your physical or mental condition; or
- Pose a threat to any provider, any Neighborhood member, or employee.

Section 3.4 Membership Termination for Misrepresentation or Fraud

We may terminate your coverage for misrepresentation or fraud. If your coverage ends for misrepresentation or fraud, we may not allow you to re-enroll for coverage with us under any other plan (such as an employer's plan) or type of coverage (for example, coverage as a dependent or spouse).

Examples of **misrepresentation** or **fraud** include:

- False or misleading information on your application
- Enrolling as a spouse someone who is not your spouse
- Receiving benefits for which you are not eligible
- Keeping for yourself payments made by Neighborhood that were intended to be used to pay provider
- Allowing someone else to use your member ID card

Date of Termination

If we terminate your coverage for misrepresentation or fraud, your coverage will end as of a later date chosen by us. We reserve the right to revoke coverage and deny payment of claims retroactive to your effective date for any false or misleading information on your application.

Should Healthsource RI or Neighborhood decide to end your enrollment, HealthSource RI will provide notice of termination at least 30 days prior to termination that includes the reason for termination.

We will pay for all covered services you received between: your effective date; and your termination date, as chosen by us. We may retroactively terminate your coverage back to a date no earlier than your effective date. We may use any premium you paid for a period after your termination date to pay for any covered services you received after your termination date. The premium may not be enough to pay for that care. In this case, Neighborhood, at its option, may pay the provider for those services and ask you to pay us back; or not pay for those services. In this case, you will have to pay the provider for the services.

SECTION 4 HIPAA CERTIFICATE OF CREDITABLE COVERAGE

When your coverage ends, we will send to you a **HIPAA Certificate of Creditable Coverage** to provide evidence of your prior health coverage. The information in the certificate lets your new health plan know how long you have had coverage, so you can receive credit for it. This information may help you obtain a special enrollment under a new plan or get certain types of individual health coverage even if you have a health condition. We will also send to you a HIPAA Certificate of Creditable Coverage upon request.

SECTION 5 CONTINUATION OF COVERAGE

Coverage is guaranteed renewable and Neighborhood may non-renew or cancel coverage only for non-payment of premiums, fraud, market exit, movement outside of service area, or if the member is no longer eligible.

CHAPTER 8 OTHER PLAN PROVISIONS

SECTION 1 GENERAL LEGAL PROVISIONS

Section 1.1 Subrogation

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

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

Neighborhood may cover health care costs for which a third party is responsible. In this case, we may require that third party to repay us the full cost of all such benefit provided by this plan. Our **rights of recovery** apply to any recoveries made by you or on your behalf from any source.

This includes, but is not limited to:

- Payments made by a third party
- Payments made by any insurance company on behalf of the third party
- Any payments or rewards under an uninsured or underinsured motorist coverage policy
- Any disability award or settlement
- Medical payments coverage under any automobile policy
- Premises or homeowners' medical payments coverage
- Premises or homeowners' insurance coverage
- Any other payments from a source intended to compensate you for third party injuries

We have the right to recover those costs in your name. We can do this with or without your consent, directly from that person or company. Our right has priority, except as otherwise provided by law. We can recover against the total amount of any recovery, regardless of whether all or part of the recovery is for medical expenses or the recovery is less than the amount needed to reimburse you fully for the illness or injury.

Personal Injury Protection/Medical Payment Benefits

You may be entitled to benefits under your own or another individual's automobile coverage, regardless of fault. These benefits are called Personal Injury Protection (PIP) and Medical Payments (MedPay) benefits. To the extent permitted under applicable state law, our coverage is secondary to both PIP and MedPay benefits. If we pay benefits before PIP or MedPay benefits have run out, we may recover the cost of these benefits as noted above.

Neighborhood's Right of Reimbursement

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

This provision applies in addition to the rights described above. You may recover money by suit, settlement, or otherwise. If this happens, you are required to reimburse us for the cost of health care services, supplies, medications, and expenses for which we paid or will pay.

This right of reimbursement starts when: (1) we have provided health care benefits for expenses where a third party is responsible, and (2) you got any amounts from any sources. This includes, but is not limited to:

- Payments made by a third party
- Payments made by any insurance company on behalf of the third party
- Any payments or awards under an uninsured or underinsured motorist coverage policy.
- Any disability award or settlement
- Medical payments coverage under any automobile policy
- Premises or homeowners' medical payments coverage
- Premises or homeowners' insurance coverage
- Any other payments from a source intended to compensate you, where a third party is responsible

We have the right to be paid by you up to the amount of any payment received. This is regardless of whether: (1) all or part of the payment to you was designated, allocated, or characterized as payment for medical expenses or (2) the payment is for an amount less than that necessary to compensate you fully for the illness or injury.

Member Cooperation

You further agree:

- To notify us promptly and in writing when notice is given to any third party or representative of a third party of the intention to investigate or pursue a claim to recover damages or obtain compensation
- To cooperate with us and provide us with requested information

- To do whatever is necessary to secure our rights of subrogation and reimbursement under this plan
- To assign us any benefits you may be entitled to receive from a third party. Your assignment is up to the cost of health care services and supplies, and expenses, that we paid or will pay for your illness or injury.
- To give us a first priority lien on any recovery, settlement, or judgment or other source of compensation which may be had by any third party. You agree to do this to the extent of the full cost of all benefits associated with third party responsibility.
- To do nothing to prejudice our rights as described above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this plan.
- To serve as a constructive trustee for the benefit of the plan over any settlement or recovery funds received as a result of third party responsibility.
- That we may recover the full cost of all benefits provided by this plan without regard to any claim of fault on your part, whether by comparative negligence or otherwise
- That no court costs or attorney fees may be deducted from our recovery
- That we are not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by you to pursue your claim or lawsuit against any third party without our prior express written consent
- That in the event you or your representative fails to cooperate with Neighborhood, you will be responsible for all benefits provided by this plan in addition to costs and attorney's fees incurred by Neighborhood in obtaining repayment

Workers' Compensation

Employers provide **workers' compensation insurance** for their employees. Employers do this to protect them in case of work-related illness or injury.

If you have a work-related illness or injury, you and your employer must ensure that all medical claims related to the illness or injury are billed to your employer's workers' compensation insurer. We will not provide coverage for any injury or illness for which it is determine that the member is entitled to benefits pursuant to: (1) any workers' compensation statute or equivalent employer liability or (2) indemnification law. This is the case whether or not the employer has obtained workers' compensation coverage as required by law.

We may pay for costs of health care services or medications for any work-related illness or injury. If we do this, we have the right to recover those costs from you, the person, or company legally obligated to pay for such services, or from the provider. If your provider bills services or medications to us for any work-related illness or injury, please call Neighborhood Member Services at 1-855-321-9244.

Subrogation Agent

We may contract with a third party to run subrogation recoveries. In such cases, that subcontractor will act as our agent.

Constructive Trust

By accepting benefits from Neighborhood, you agree that if you receive any payment from any responsible party because of an injury, illness, or condition, you will serve as a constructive trustee over the funds that constitute such payment. This is the case whether the payment of such benefits is made to you directly or made on your behalf (for example, to a provider). Failure to hold the funds in trust will be deemed a breach of your fiduciary duty to Neighborhood.

Section 1.2 Amendments to this Agreement

We reserve the right, without your approval, to change, interpret, modify, withdraw, or add benefits or terminate the agreement. Any provision of the agreement which is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the agreement is delivered) is amended to conform to the minimum requirements of such statutes and regulations. No other change may be made to the agreement unless it is made by an amendment or rider signed by one of our officers. All of the following conditions apply:

- Amendments to the agreement are effective 31 days after we send written notice.
- Riders are effective on the date we specify.
- No agent has the authority to change the agreement or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the agreement.

Section 1.3 Genetic Information

We do not limit your coverage based on genetic information. We will not:

- Adjust premiums based on genetic information.
- Request or require an individual or family member of an individual to have a genetic test.
- Collect genetic information from individual or family member of an individual before, in connection with enrollment, or at any time for underwriting purposes.

Section 1.4 Our Rights to Make Payments and Recover Overpayments

If payments which should have been made by us according to this provision have actually been made by another organization, we have the right to pay those organizations the amounts we decide are necessary to satisfy the rules of this provision. These amounts are as benefits under this agreement and we are not liable for them.

If we have made payments for allowable expenses which are more than the maximum amount needed to satisfy the conditions of this provision, we have the right to recover the excess amounts from: the person to or for whom the payments were made, any other insurers, and/or any other organizations (as we decide). As the subscriber, you agree to pay back any excess amount, provide information and assistance, or do whatever is necessary to recover this excess amount.

Section 1.5 Limitation of Action

You cannot bring any legal action against us to recover reimbursement prior to the expiration of 60 days after a request for benefits has been filed and no such action can be brought at all unless brought within three years from the expiration of time to submit a request for benefits.

Section 1.6 Circumstances Beyond Neighborhood's Control

Neighborhood will not be responsible for a failure or delay in arranging for the provision of services in cases of circumstances beyond the reasonable control of Neighborhood. Such circumstances include, but are not limited to major disaster, epidemic, strike, war, riot, and civil insurrection. In such circumstances, we will make a good faith effort to arrange for the provision of services. In doing so, we will take into account the impact of the event and the availability of network providers.

Section 1.7 Patient Protection Disclosure

You do not need preauthorization from Neighborhood or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining preauthorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specializes in obstetrics or gynecology, call Neighborhood Member Services at 1-855-3219244 or visit our website at www.nhpri.org.

SECTION 2 YOUR RELATIONSHIP WITH US

We do not provide medical services or make treatment decisions. This means:

- We do not decide what care you need or will receive. You and your physician make those decisions.
- We communicate to you decisions about whether the plan will cover or pay for the health care that you may receive.
- The plan may not pay for all treatments you or your physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

SECTION 3 OUR RELATIONSHIP WITH NETWORK PROVIDERS

The relationships between us and our providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees. We and our employees are not agents or employees of network providers. We do not provide health care services or supplies. We do not practice medicine. We arrange for health care providers to be part of a network and we pay benefits. Network providers are independent providers who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials. It does not ensure the quality of the services provided. They are not our employees and we do not have any other relationship with network providers. We are not liable for any act or omission of any provider.

SECTION 4 YOUR RELATIONSHIP WITH NETWORK PROVIDERS

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any deductible, co-insurance, co-payment, and any amount that exceeds eligible expenses.
- You are responsible for paying, directly to your provider, the cost of any non-covered service.
- You must decide if any provider treating you is right for you. This includes network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

SECTION 5 HOW WE COORDINATE YOUR BENEFITS WHEN YOU ARE COVERED BY MORE THAN ONE PLAN

Section 5.1 Introduction to Coordination of Benefits (COB)

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

We follow the COB rules of payment issued by the National Association of Insurance Commissioners. OHIC has adopted the COB rules. From time to time, these rules may change before we issue a revised Certificate of Coverage. We use the COB regulations in effect at the time of coordination to determine benefits available to you under this agreement.

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

Section 5.2 Definitions

The following definitions apply to Section 5:

Allowable Expense: 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 both an allowable expense and a benefit paid.

- **Benefits**: Any treatment, facility, equipment, drug, device, supply or service for which you receive reimbursement under a plan.
- **Claim**: A request that benefits of a plan be provided or paid.
- **Plan**: Any health care insurance benefit package.
- **Primary Plan**: 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**: A plan which is not a primary plan.

Section 5.3 When You Have More Than One Agreement with Neighborhood

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

Section 5.4 How We Manage Your Benefits When You are Covered by More Than One Plan

When You are Covered by More Than One Insurer

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

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

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

- Whether you are the main subscriber or a dependent.
- If married, whether you or your spouse was born earlier in the year or length of time each spouse has been covered.
- Non-Dependent/Dependent: If you are covered under a plan and you are the main subscriber, the benefits of that plan will be determined before the benefits of a plan, which covers you as a dependent. If, however, you are a Medicare beneficiary, then, in some instances, Medicare will be secondary and the plan, which covers you as the main subscriber or as a dependent, will provide the benefits first.
- If one of your dependents covered under this agreement is a student, the benefits of any other coverage available because of student enrollment (except accident-only type coverage) will be determined before the benefits under this agreement.
- Dependent Child/Parents Not Separated or Divorced: If dependent children are covered under separate plans of more than one person (i.e., parents or individuals acting as parents), the benefits of the plan covering the parent born earlier in the year will be determined before those of the parent whose birthday falls later in the year. If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan, which covered the other parent for a shorter period of time. The term “birthday” only refers to the month and day in a calendar year, not the year in which the person was born. If the other plan does not determine benefits according to the parents' birth dates, but by parents' gender instead, the other plan's gender rule will determine the order of benefits.
- Dependent Child/Parents Separated or Divorced:
    - If two or more plans cover a person as a dependent child of divorced or separated parents, the plan responsible to cover benefits for the child will be determined in the following order:
        - First, the plan of the parent with custody of the child;

        - Then, the plan of the spouse of the parent with custody of the child; and
        - Finally, the plan of the parent without custody.
    - If the terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the parent's benefits under that parent's plan has actual knowledge of those terms, the benefits of that plan are determined first and the benefits of the plan of the other parent are the secondary plan.
    - If the terms of a court decree state that the parents share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in the section above.
- Active/Inactive Employee: If you are covered under another health plan as an employee (not laid off or retired), your benefits and those of your dependents under that plan will be determined before benefits under this plan.
- Longer/Shorter Length of Coverage: If none of the above rules determines the order of benefits, the benefits of the plan, which covered a member or subscriber longer, are determined before those of the plan, which covered that person for the shorter term.

In general, if you use more benefits than you are covered for during a benefit period, the following formula is used to determine coverage:

- The insurer covering you first will cover you up to its allowance. Then, the other insurer will cover any allowable benefits you use over that amount. It will never be more than the total amount of coverage that would have been provided if benefits were not coordinated.
- Maximum benefits paid by first insurer plus any remaining allowable expense paid by other insurer equals total benefits paid.

CHAPTER 9 DEFINITIONS OF IMPORTANT WORDS

Appeal: When you make an appeal, you are asking Neighborhood to reconsider a decision.

Balance Billing: When a provider bills you for the difference between their charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. Your Neighborhood plan does not allow providers to balance bill.

Benefit Limit: For some services, your plan may limit the dollar amount, the duration, or the number of visits for covered health care services. For services beyond this amount you will be required to pay out-of-pocket to the network provider. This is known as a benefit limit. You will be responsible for any expenses that exceed the designated benefit limits. Please see Chapter 1 Summary of Medical and Prescription Drug Benefits for details on benefit limits for specific services.

Benefit Year: For members of an individual market plan: a 12-month calendar year or the remainder of a 12-month calendar year if you enroll later than January 1 of that year. For members of a small group market plan: a 12-month period beginning upon enrollment effective date.

Certificate of Coverage (COC): This document and any future amendments, which describes the benefits under this benefit year.

Charges: The amount billed by any health care provider (e.g., hospital, provider, laboratory, etc.) for health care services without the application of any discount or negotiated fee arrangement.

Claim: A request that benefits of a plan be provided or paid.

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

Co-Insurance: An amount you may be required to pay as your share of the cost for services. Co-insurance is usually a percentage.

Complaint: A type of complaint you make about us or one of our network providers, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes (see Chapter 6).

Co-Payment: An amount you may be required to pay as your share of the cost for a covered service or supply, like a provider's visit, hospital outpatient visit, or a prescription. A co-payment is usually a set amount, rather than a percentage.

Cost-Sharing: The cost you pay for covered services. This amount may consist of deductibles, co-insurance, and/or co-payments.

Covered Service: The services and supplies for which we will pay. They must be described in Chapter 4 of this agreement and be medically necessary. Covered services do not include any

tax, surcharge, assessment, or other similar fee imposed under any state or federal law or regulation on any provider, member, service, supply, or medication.

Deductible: The amount that you must pay each benefit year before our plan begins to pay for certain covered health care services. The deductible may not apply to all services.

Dentally Necessary (*Dental Necessity*): These termsmean that the dental services provided are appropriate , in terms of type, amount, frequency, level, setting, and duration to the member's diagnosis or condition. All covered services must be dentally necessary and appropriate to qualify for payment. Delta Dental will make a determination whether a service is dentally necessary based on this "dental necessity" standard using criteria which is set forth in the utilization review plan and guidelines ("review guideline") that Delta Dental files with the Rhode Island Office of the Health Insurance Commissioner. These guidelines are based on generally accepted dental or scientific evidence and are consistent with generally accepted practice parameters. If a service is denied based on dental necessity, Delta Dental will send you and your dentist a written notice explaining the reason(s) for the denial. The notice will refer to a guideline; protocol; or, criteria Delta Dental used to make the denial. A copy of Delta Dental's review guidelines is available at: www.deltadentalri.com.

Dentist: A dentist is any person licensed as a Doctor of Dental Medicine (DMD) or Doctor of Dental Surgery (DDS) practicing within the authority of his or her license. The term dentist includes an oral surgeon.

Developmental Services: Therapies, typically provided by a qualified professional using a treatment plan intended to lessen deficiencies in normal age appropriate function. The therapies used 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.

Durable Medical Equipment (DME): Equipment and supplies your provider (for example, a provider or hospital) orders for your everyday or extended use. DME can withstand repeated use. Examples include oxygen equipment, wheelchairs, crutches or blood testing strips. DME is used in the home.

Effective Date: The date, according to our records, when you become a member and are first eligible for covered services

Endodontics: A specialty of dentistry that deals with treatment of dental pulp disease (nerves, blood vessels and other tissues within the tooth). A root canal is an example of endodontic treatment.

Experimental or Investigative: A service, supply, treatment, procedure, device, or medication (collectively "treatment") is considered experimental or investigative if any of the following apply:

- The drug or device cannot be lawfully marketed without the approval of the FDA. Approval for marketing has not been given at the time the drug or device is furnished or to be furnished.
- The treatment, or the "informed consent" form used with the treatment, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or federal law requires such review or approval.
- Reliable evidence shows that the treatment is under study to determine its safety, efficacy, toxicity, maximum tolerated dose, or its efficacy as compared with a standard means of treatment or diagnosis.
- Evaluation by an independent health technology assessment organization has determined that the treatment is not proven safe and/or effective in improving health outcomes or that appropriate patient selection has not been determined.
- The peer-reviewed published literature regarding the treatment is predominantly non- randomized, historically controlled, case controlled or cohort studies or there are few or no well-designed randomized, controlled trials.

Family Coverage: Coverage for a subscriber and his or her dependents.

Freestanding Ambulatory Surgery Center: A state licensed facility equipped to surgically treat patients on an outpatient basis.

Habilitative Services: Habilitative health care services that help a person keep, learn or improve skills and functioning for daily living are covered. An example is therapy for a child who is not walking or talking at the expected age.

Home Health Aide: A home health aide gives services that do not need the skills of a licensed nurse or therapist. Services include help with personal care (bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hygienist: A person licensed as a dental hygienist practicing within the authority of his or her license.

Inpatient: A patient admitted to a hospital or other health care facility. The patient must be admitted at least overnight.

Out-of-Pocket (OOP) Maximum: The most that you pay out-of-pocket during the calendar year for covered services.

Medical Necessity: Means services or supplies which, under the provisions of this Agreement, are determined to be:

- Appropriate and necessary for the type, amount, frequency, level, setting, and duration of the member’s diagnosis or condition
- Informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters
- Provided for preventative care, or for diagnosis or direct care and treatment of a member's medical condition or mental health status

- Not primarily for the convenience of the member, the member's physician, or another health care provider
- The most appropriate supply or level of service that can be provided safely

For inpatient hospital services, this means that acute care as an inpatient is necessary due to the kind of services the member is receiving or the severity of the member's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensive medical setting.

We will make a determination whether a health care service is medically necessary. You have the right to appeal our determination or to take legal action as described in Chapter 6. We review medical necessity on a case-by-case basis.

Medically Necessary Orthodontics: The patient under age 19 must have severe and handicapping malocclusion (faulty contact of upper and lower teeth in biting); as defined by Delta Dental of Rhode Island's review guidelines.

Member: A person who is eligible for covered a service and has enrolled in our plan.

Neighborhood Member Services: The department responsible for answering member questions about your membership, benefits, complaints, and appeals.

Network Provider: A provider that has entered into an agreement with us.

Out-of-Network Provider or Facility: A provider that has not entered into an agreement with us.

Out-of-Pocket (OOP) Costs: See the definition for cost-sharing above. A member's cost-sharing requirement to pay for a portion of services received is also referred to as the member's out-of-pocket cost requirement.

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

Pedodontics: A specialty of dentistry concerned with the treatment of children.

Periodontics: A specialty of dentistry concerned with diseases of the gum and other supportive structures of the teeth.

Preauthorization: A decision that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Preauthorization is not a guarantee of payment, as the process does not take benefit limits or eligibility at the time of the service into account.

Network providers are responsible for getting preauthorization for all applicable covered health care services. You are responsible for getting preauthorization when the provider is out-of-network. If you do not get 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 telephone. For covered health care services (other than behavioral health services and pediatric dental services), call Neighborhood Member Services at 1-855-321-9244.

For behavioral health services, please call 1-833-470-0578. We recommend you contact us as soon as possibly but within 3 business days for any covered health care services for which preauthorization is required. . Services for which preauthorization is required are noted in the Summary of Medical and Prescription Drug Benefits chart in Chapter 1.

For pediatric dental services, please call our partner Delta Dental 1-800-843-3582. Services for which prior authorization is required are noted in the Summary of Pediatric Dental Benefits chart in Chapter 1, section 4.

Premium: The total monthly cost of individual or family coverage that the subscriber pays to Neighborhood.

Preventive Care Services: Covered health care services performed to prevent the occurrence of disease.

Primary Care Provider (PCP): A network provider who provides primary care services (including family practice, general practice, internal medicine, obstetrics and gynecology, and/or pediatrics), manages routine health care needs, and is the primary care provider for one or more members.

Prosthodontics: A specialty of dentistry concerned with the replacement of missing teeth by bridges and dentures.

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

Rehabilitative Services: Acute (serious) 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 60 days. 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.

Semi-Private Room: A hospital room with two or more patient beds.

Single Co-payment: An amount you may be required to pay as your share of the cost when you receive a behavioral health and primary care visit with a qualifying integrated primary care practice on the same day and in the same location. A co-payment is usually a set amount, rather than a percentage.

Skilled Nursing Facility Care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a Skilled Nursing Facility. Examples of Skilled Nursing Facility care include physical therapy or intravenous injections that can only be given by a registered nurse or provider.

Skilled: A type of care that is medically necessary. This care must be provided by, or under the direct supervision of, licensed medical personnel. Skilled care is provided to achieve a medically desired and realistically achievable outcome.

Spouse: The subscriber's legal spouse, according to the law of the state in which you reside. Spouse also includes the spousal equivalent of the subscriber who is the registered civil union partner, domestic partner, or other similar legally recognized partner of the subscriber who resides in a state or municipal jurisdiction that provides such legal recognition/spousal equivalent rights.

Subscriber: A subscriber is the person who signs and submits an application for health care coverage for him/herself and any dependents.

Substance Use: Ongoing abuse of alcohol or other drugs. The term "substance" includes alcohol and addictive drugs. It does not include caffeine or tobacco.

Substance Use Treatment Facility: A hospital or facility which is licensed by HEALTH as a hospital or as a community residential facility for substance use or substance use treatment, unless we can establish through a pre-admission certification process that services are not available at a facility that meets these requirements

Urgent Care Center: A health care center physically separate from a hospital or other institution with which it is part. It may also mean an independently operated and owned health care center. These centers are also called walk-in centers.

TELEPHONE NUMBERS

AND OTHER CONTACT INFORMATION

Call	**1-855-321-9244 Neighborhood Member Services** **1-833-470-0578 Behavioral Health Member Services** **1-800-843-3582 Delta Dental of Rhode Island Customer Service** • Neighborhood Member Service Specialists are available Monday through Friday 8:00 am to 6:00 pm • Telephone Interpreters available for non-English speakers • Calls to this number are free
TTY	**Dial 711** • Neighborhood Member Service Specialists are available Monday through Friday 8:00 am to 6:00 pm • This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking • Calls to this number are free
Fax	**1-401-459-6021**
Write	**Neighborhood Health Plan of Rhode Island** **910 Douglas Pike** **Smithfield, RI 02917**
Website	www.nhpri.org