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

PPO Plans
January 2016

Consumer Disclosure

Safe and Healthy Lives in Safe and Healthy Communities

Consumer Disclosure

CONSUMER'S RIGHT TO KNOW ABOUT HEALTH PLANS

Tufts Health Plan – Rhode Island PPO Plans
January 2016

THE HEALTH CARE ACCESSIBILITY AND QUALITY ASSURANCE ACT

WHY ARE YOU GETTING THIS INFORMATION?

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

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

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

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

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

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Member Services Department
Tufts Health Plan
705 Mount Auburn Street
P.O. Box 9170
Watertown, MA 02471-9170
Toll-free Numbers: 1-800-682-8059; TDD 1-800-868-5850
Fax: 617-923-5517
Email Addresses: ***hmo@tufts-health.com***
Para contactor a un representante que hable Espanol, llame a:
Nombre del Representante del Plan 1-800-682-8059.
1-866-352-9114 (CareLink)

Plan information is also available on-line at: **www.tuftshealthplan.com**

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

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Tufts Health Plan pays benefits only for covered services that are medically necessary. The criteria for medical necessity, as determined by the Plan, include: that the services are essential to identify or treat an illness or injury, are appropriate for your condition, meet general medical standards and Tufts Health Plan's Clinical Coverage Guidelines, and are provided at the appropriate level, time and setting. In order to determine whether treatment is or was medically Necessary, Tufts Health Plan reviews:

- proposed treatment before it begins;
- treatment as it occurs; and
- treatment after services have been provided.

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

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You do not need approval from Tufts Health Plan before receiving Emergency care. Follow these guidelines when you need Emergency care.

- If needed, call 911 for emergency medical assistance. If 911 services are not available in your area, call the local number for emergency medical services.
- Go to the nearest emergency medical facility.
- If you receive outpatient Emergency care at an emergency facility, you or someone acting for you should call Tufts Health Plan within 48 hours after receiving care. You are encouraged to contact your physician so he or she can provide or arrange for any follow-up care that you may need.
- If you are admitted as an Inpatient, you or someone acting for you should call Tufts Health Plan within 48 hours after receiving care.

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

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When you get covered services from a Participating Provider, Tufts Health Plan will pay for those covered services at the In-Network Level of Benefits. You may choose instead to get covered services from an Out-of-Network Provider. If this occurs, the Plan will pay for those covered services at the lower Out-of-Network Level of Benefits*.

*Note: In accordance with the Affordable Care Act (federal health care reform), emergency care services you get from an Out-of-Network Provider are covered at the In-Network Level of Benefits.

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

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The Plan does not require you to get a second opinion. As a Tufts Health Plan member, you have the right to get a second opinion if you want one. The Plan will pay, at least in part, for a second opinion even if it is not required.

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

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The Plan strongly believes in safeguarding the privacy of our members' protected health information (PHI). The Plan uses and discloses PHI in a number of ways to carry out our responsibilities as a managed care plan (e.g. payment and healthcare operations purposes). The Plan protects oral, written and electronic PHI throughout our organization and does not sell PHI to anyone. There are a number of internal policies and procedures designed to control and protect the internal security of PHI and all employees receive training on the policies and procedures. Our policies and procedures are evaluated and updated for compliance with applicable laws. Before disclosing PHI to organizations that help perform normal business functions, the Plan obtains assurances from them that they will appropriately safeguard the PHI.

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

A

Tufts Health Plan does not discriminate against members due to age, sex, religion, race or ethnic origin, disability, occupational status or other characteristics protected by law.

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

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Tufts Health Plan members have the right to refuse the treatment recommendations of a Tufts Health Plan Provider. Any future medically necessary treatment would be covered.

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

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Tufts Health Plan may have a capitated reimbursement arrangement or other similar risk sharing arrangement and other financial arrangements with your provider.

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

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If Tufts Health Plan renews your coverage, it will occur on your employer's anniversary date. At renewal, some provisions may change, including out-of-pocket costs and premiums. The Plan will cancel your coverage, in accordance with Rhode Island law, if: you voluntarily disenroll, you lose eligibility because you no longer meet your employer's or the Plan's eligibility rules, your employer's contract with the Plan ends, or you engage in misrepresentation or fraud.

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

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When you enroll, you will be asked to identify any other health benefits plan or insurance coverage you and your enrolled dependents may have. The Plan may ask you to provide such information as insurance carrier name, plan name, and the effective date for the other health benefit plan(s) or insurance coverage(s). The Plan may ask you to update this information from time to time.

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

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

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

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

COVERED SERVICES AT A GLANCE

Annual Deductible (In-Network): Indiv - $500 up to $6,850, depending on plan / Family - $1,000 up to $13,700, depending on plan
Annual Deductible (Out-of-Network): Indiv - $1,000-$13,700, depending on plan / Family - $2,000 up to $27,400, depending on plan
Max Lifetime Cap: Indiv.- not applicable; Family- not applicable

Type of Service (Not all services are listed) **Call plan or check official plan documents for details**	Is prior authorization required? (Yes/No)	What out of pocket expenses will I have to pay?	What other limitations apply?	If I choose a non-participating provider, will the service be covered?
Ambulance	Yes, in some cases	$50 copayment per trip or Deductible then covered in full	Non-emergency ambulance transport only provided to or from nearest hospital or other covered facility. Non-emergency ambulance transport for Medically Necessary care only provided when the medical condition of the Member prevents safe transportation by any other means.	Yes. Cost sharing and limitations are the same as for participating providers.
Chiropractic Treatment	No	$[0-75] copayment per visit or Deductible then [0-20]% coinsurance.	Coverage is limited to 12 visits per year whether obtained from a participating or non-participating provider.	Yes. Deductible then [20-40]% coinsurance.
Dental Care	Not applicable.	Not applicable.	Coverage may include pediatric dental care for members under age 19. Contact the plan for more information.	Yes. Deductible then [20-40]% coinsurance.
Diagnostic X-rays, Imaging and Laboratory Tests	Yes, in some cases.	Laboratory tests and general imaging: $[0-75] copayment or Deductible then [0-20]% coinsurance. MRI/MRA, CT/CTA, PET, and nuclear cardiology imaging: $[0-350] copayment per visit or Deductible then [0-20]% coinsurance.	Services must be ordered by physician.	Yes. Deductible then 20%-40% coinsurance.
Emergency Services	No	$[0-350] copayment per visit or Deductible then [0-20]% coinsurance.	Copayment waived if emergency room visit results in immediate inpatient hospitalization.	Yes. Cost sharing and limitations are the same as for participating providers.
Experimental Treatments	Not required for approved clinical trials	See Hospitalization and Inpatient Services, Physician Office Visits and other relevant services.	Coverage applies to “approved clinical trials” as defined under Rhode island and federal law.	Yes. Deductible then [20-40]% coinsurance.
Eye Care	No	See Physician Office Visits and Surgery, Outpatient	Coverage for routine eye exams is limited to one exam each year. Pediatric vision coverage is provided for members under age 19. Contact plan for more information	Yes. Deductible then [20-40]% coinsurance, after deductible.

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COVERED SERVICES AT A GLANCE

Annual Deductible (In-Network): Indiv – $500 up to $6,850, depending on plan / Family – $1,000 up to $13,700, depending on plan
Annual Deductible (Out-of-Network): Indiv – $1,000 up to $13,700, depending on plan / Family – $2,000 up to $27,400, depending on plan
Max Lifetime Cap: Indiv.- not applicable; Family - not applicable

Type of Service (Not all services are listed) **Call plan or check official plan documents for details**	Is prior authorization required? (Yes/No)	What out of pocket expenses will I have to pay?	What other limitations apply?	If I choose a non-participating provider, will the service be covered?
Foot Care	Yes, in some cases.	See Physician Office Visits and Surgery, Outpatient	Limited to surgery and treatment of the foot. Routine foot care is not covered except as medically necessary for members diagnosed with diabetes.	Yes. Deductible then [20-40]% coinsurance.
Health Education & Wellness	No	Discounts vary depending on program	N/A	No. Not Covered
Home Health Care	Yes, in some cases.	Deductible then [0-20]% coinsurance.	Must be part of approved home care plan; member must be homebound.	Yes. Deductible then [20-40]% coinsurance.
Hospice Care	No	Deductible then [0-20]% coinsurance.		Yes. Deductible then [20-40]% coinsurance.
Hospitalization and Inpatient Services	Yes, in some cases.	Deductible then [0-20]% coinsurance per admission.	Semi-private room.	Yes. Deductible then [20-40]% coinsurance.
Maternity	No	Outpatient Routine: Covered in full in-network. Outpatient Non-Routine: $[0-75] copayment per visit or Deductible then [0-20]% coinsurance. Inpatient: Deductible then [0-20% coinsurance per admission.	Coverage for a minimum inpatient hospital stay (48 hours for vaginal delivery; 96 hours for caesarean delivery)	Yes. Deductible then [20-40]% coinsurance.
Medical Equipment and Supplies	Yes, in some cases.	Deductible then [0-30]% coinsurance.	Equipment purchase/rental limitations. Supplies must be obtained from contracted vendor. Coverage for hearing aids per Rhode Island law. Call plan with questions about specific equipment and supplies.	Yes. Deductible then 10%-40]% coinsurance

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COVERED SERVICES AT A GLANCE

Annual Deductible (In-Network): Indiv – $500 up to $6,850, depending on plan / Family – $1,000 up to $13,700, depending on plan
Annual Deductible (Out-of-Network): Indiv – $1,000 up to $13,700, depending on plan / Family – $2,000 up to $27,400, depending on plan
Max Lifetime Cap: Indiv.- not applicable; Family - not applicable

Type of Service (Not all services are listed) **Call plan or check official plan documents for details**	Is prior authorization required? (Yes/No)	What out of pocket expenses will I have to pay?	What other limitations apply?	If I choose a non-participating provider, will the service be covered?
Mental Health, Inpatient	Yes, in some cases.	Deductible then [0-20]% coinsurance per admission.	Semi-private room	Yes. Deductible then 20%-40% coinsurance.
Mental Health, Outpatient	No	$[0-75] copayment per visit or Deductible then [0-20]% coinsurance		Yes. Deductible then 20%-40% coinsurance.
Nursing Home Care	Yes, in some cases.	Deductible then [0-20]% coinsurance per admission.	Coverage is provided for skilled care only; custodial care is not covered.	Yes. Deductible then 20%-40% coinsurance.
Physician Office Visits	No	$[0-75] copayment per visit or Deductible then [0-20]% coinsurance per visit.	Preventive/wellness visits covered in full per federal ACA guidelines.	Yes. Deductible then 20-40% coinsurance.
Prescription Drugs	May be required for certain drugs.	30-day supply at retail pharmacy: Tier 1: $[0-50] copayment Tier 2; $[0-75] copayment Tier 3: $[0-150] copayment Tier 4: $[0-500] copayment Up to 90-day supply also available at retail and mail order	Drug formulary applies. Mail order available. May be subject to prescription drug deductible ($0-$600 individual; $0-$1,800 family). Subject to pharmacy management programs.	Prescriptions obtained from non-contracted pharmacies are reimbursed at the in-network level of benefits
Rehabilitation, Outpatient (PT/OT/Speech Therapy)	Yes, in some cases.	$[0-$75] copayment per visit or Deductible then [0%-20]% coinsurance.	Number of visits is limited. Contract plan for specific information.	Yes. Deductible then 20%-40% coinsurance.
Substance Abuse, Inpatient	Yes, in some cases.	Deductible then [0-20]% coinsurance per admission.		Yes. Deductible then 20%-40% coinsurance.
Substance Abuse, Outpatient	No	$[0-75 copayment per visit or Deductible then [0-20]% coinsurance.		Yes. Deductible then 20%-40% coinsurance.
Surgery, Outpatient	Yes, for certain services.	Deductible then [0-20]% coinsurance		Yes. Deductible then 20%-40% coinsurance.

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