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

***BLUE CROSS DENTAL DIRECT***
SERIES C (11/06)

***BLUE CROSS & BLUE SHIELD OF RI***
***January 1, 2008***

# ***Consumer Disclosure***
**Single Service Plan Edition**

*Safe and Healthy Lives in Safe and Healthy Communities*
**Consumer Disclosure**

**Blue Cross Dental Direct**

**Effective Date of Disclosure: January 2008**

**CONSUMER'S RIGHT TO KNOW ABOUT HEALTH PLANS**
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, http://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:

**A**

Blue Cross & Blue Shield of Rhode Island
Customer Service Department
500 Exchange Street
Providence, RI 02903

Toll-free 1-800-527-7290; Telephone 401-831-7300; Fax: 401-459-2006;
TDD Number 401-831-2202; Internet www.BCBSRI.com.

These phone numbers can be used to: a) confirm the status of any provider; b) receive administrative or appeal process information; c) file a complaint; d) receive timely access information.

Para contactor a un representante que hable Espanol, llame a:
Departamiento de Servicios Para Miembros 1-800-527-7290.

**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.

**A**

Covered dental services are listed in your official plan document. We recommend pre-authorization (prior authorization) for crowns, inlays/onlays, and surgical and non-surgical periodontics (treatment of gums). If you receive services from a participating dentist, the dentist will be responsible for obtaining pre-authorization for you.

You may appeal any review determination within one hundred eighty (180) days of receipt of the determination. We will review your appeal and respond to you within fifteen (15) days of receipt of the appeal request. If your appeal is denied, you may request a second appeal under the same terms as above. If your second appeal is denied, you may request an external appeal. An external appeal is reviewed by an agency that is not affiliated with us.

**Q** **What if I have an emergency?** An emergency is a problem that needs to be seen 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.

**A**

This dental plan covers minor emergency treatment to reduce or relieve acute dental pain (Consult your official plan document for a list of covered services). This dental plan does not cover hospital emergency room services; check your health plan to determine hospital emergency room coverage.

**Q** **What if I refuse referral to a participating provider:** 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.

**A**

This question is not applicable to this dental plan.

**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.

**A**

This question is not applicable to this dental plan.

**Q** **How does the Health Plan makes 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.

**A**

We will release information about your health, treatment or condition to authorized doctors, health care providers, facilities, and insurers to coordinate your benefits and pay claims. Access to personally identifiable information is limited to persons who need to know. Our employees are instructed to keep such information confidential and sign a statement promising to do so. If an employee violates a member's rights to privacy and confidentiality, this is grounds for employment termination.

**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**

You have the right to receive to receive benefits for all covered services determined by the plan to be medically necessary regardless of your race, religion, gender, sexual orientation, national origin, cultural background, disability, age, financial or occupational status, or membership in other protected groups.

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

**A**

This dental plan does not restrict your right to refuse treatment. You may refuse treatment at your discretion. This refusal will not affect your access to future treatment, dental plan coverage, or payment for services.

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

**A**

This dental plan is not capitated and does not contain other risk sharing arrangements.

**Q** **How is coverage renewed or canceled?**

**A**

This dental plan will be renewed automatically on its calendar anniversary date. Your coverage may only be cancelled if you fail to pay membership fees due, if you cease to be eligible for coverage under the plan, if fraud is documented, if we find that you've abused or disregarded a dentist's protocols (e.g., behaved disruptively in a dentist's office, repeatedly refused to accept dentist-recommended procedures or treatment, or impaired your dentist's ability to provide care), or if we stop offering this type of coverage.

**Q** **If I am covered by two or more health plans, what should I do?** If you or a family member is 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.

**A**

This dental plan will ask:
**I**f you are the main subscriber or a dependent;
**Y**our marital status, date of birth (yours and your spouse's) or length of time covered;
**I**f you are a Medicare beneficiary;
We may ask for other information not listed here if necessary to coordinate payments.

**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

All services are covered up to a $1,000 calendar year maximum per member.
There is no annual deductible for covered services. Members must be enrolled in the Plan for twelve (12) consecutive months before benefits become available for Major Restorative Services.

### Basic Services

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|---|---|
| **Preventive/Diagnostic Services** | |
| Exams 100% | One initial or periodic routine oral examination per calendar year including diagnosis and charting. |
| Cleanings 100% | Two cleanings per calendar year, including scaling and polishing |
| X-rays 100% | Bitewing X-rays - one set per calendar year; Full Mouth Set - one set per 60 months; Individual X-rays - as needed. |
| Fluoride Treatments 100% | One fluoride treatment per calendar year for eligible dependents to age19. |
| **Minor Restorative Services** | |
| Sealants 80% | Sealant treatments on permanent molars, with no prior restoration on the occlusal surface, are covered for members between the ages of 6 through 13. Coverage is limited to one (1) sealant treatment per three (3) year period. |
| Space Maintainers 80% | When not made of cast precious metals |
| Fillings 80% | Amalgam, treatment, composite and other resin fillings including base, subbase, pulp capping and polishing are covered. If material other than amalgam is used as a filling on posterior teeth, you are responsible to pay for any difference between our allowance for amalgam fillings and the dentist's charge. Other restorative services covered include recementing of crowns or inlays. |
| Simple Extractions 80% | Removal of an erupted tooth not requiring surgery. |
| Denture Repairs 80% | Covers services to repair broken dentures, including replacement of teeth and reattachment or replacement of clasps or facings. Rebase or reline of full or partial dentures involving laboratory procedures is limited to once in five (5) years. |
| Biopsies 80% | Limited to biopsy and examination of hard or soft oral tissue. |
| Minor Emergency Treatment 80% | Minor treatment to relieve acute dental pain. |
| Root Canal Therapy (Endodontics) 80% | Covers root canal therapy procedures, including pulpotomy for all Final restoration excluded. Vital pulpotomy for subscribers under age 11 is covered. |
| Oral Surgery 80% | Includes surgical extractions and other eligible oral surgical procedures not covered under any medical or surgical insurance plan. |

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| Non-Surgical Periodontics 80% | Covers non-surgical procedures for treatment of tissues supporting the teeth. *Pre-authorization (Prior Authorization) is recommended for all non-surgical periodontic services*. |

## Major Restorative Services

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|---|---|
| Crowns & Inlays 50% | Includes crowns and inlays which are not part of a bridge. Replacement of an existing crown is covered only if more than five years has elapsed since last placement. *Pre-authorization (Prior Authorization) is recommended for all crowns and inlays.* |
| Surgical Periodontics 50% | Covers procedures including surgery, for the treatment of tissues supporting the teeth. *Pre-authorization (Prior authorization) is recommended for all surgical periodontic services.* |
| Dependents | Covered at same level as subscriber, includes spouse and unmarried, dependent children to January 1 following their 19th birthday. |

## Limitations and Exclusions

- This dental plan does not cover services not specifically listed in the Covered Services section of our subscriber agreement.
- This dental plan does not cover general anesthesia (intravenous or inhalation) or the services of an anesthesiologist.
- This dental plan does not cover services when there is no charge to you or when they are available to you, in whole or in part, through other sources.
- This dental plan does not cover services performed only to change or improve your appearance.
- This dental plan does not cover injectable or prescription drugs.
- This dental plan does not cover new experimental and/or investigational procedures, services, or supplies.
- This dental plan does not cover procedures, services, or supplies not approved by us.
- This dental plan does not cover specialty oral examinations.
- This dental plan does not cover orthodontic or prosthetic appliances or space maintainers that are misplaced, lost or stolen.
- This dental plan does not cover dental services rendered at a hospital by interns, residents or staff dentists.
- This dental plan does not cover services rendered prior to the effective date of your agreement with us.
- This dental plan does not cover multi-stage procedures (e.g., crowns) started before the effective date of our subscriber agreement.
- This dental plan does not cover services not Dentally Necessary for the diagnosis, treatment or prevention of dental disease.
- This dental plan does not cover any services for or related to Temporomandibular Joint Dysfunction (TMJ).
- This dental plan does not cover travel or other related expenses that may be incurred by a dentist providing services.
- This dental plan does not cover veneers (bonding of coverings to the teeth).
- This dental plan does not cover implants.
- **Waiting period for Major Restorative Benefits Availability:** This dental plan does not cover crowns, inlays/onlays, and surgical periodontic services until members have been enrolled in the plan for twelve (12) consecutive months.