Blue Cross Dental Direct

Blue Cross Dental℠

Subscriber Agreement

Blue Cross Blue Shield of Rhode Island

Your Plan for Life™

Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

Series C (11/06)

BLUE CROSS & BLUE SHIELD OF RHODE ISLAND
DENTAL BENEFIT AGREEMENT

This is a legal agreement between *you* and Blue Cross & Blue Shield of Rhode Island. *Your* I.D. card or number will identify *you* as a *member* when *you* receive the dental care services covered under this agreement. By presenting *your* I.D. card to receive covered services, *you* are agreeing to abide by the rules and obligations of this agreement.

You hereby expressly acknowledge *your* understanding that this contract is solely between *you* and Blue Cross & Blue Shield of Rhode Island. Blue Cross & Blue Shield of Rhode Island is an independent Corporation operating under a license from the Blue Cross & Blue Shield Association (the "Association"), an association of independent Blue Cross & Blue Shield Plans, permitting *us* to use the Blue Cross & Blue Shield Service Marks. *We* are not contracting as the agent of the Association. *You* further acknowledge and agree that *you* have not entered into this contract based upon representations by anyone other than *us* and that no person, entity or organization other than *us* shall be held accountable or liable to *you* for any of *our* obligations to *you* under this contract. This paragraph shall not create any additional obligations on *our* part other than those obligations created under other provisions of this agreement.

James E. Purcell
President and Chief Executive Officer

Frank J. Montanaro
Chairman

Series C (11/06)

Blue Cross & Blue Shield of Rhode Island
Blue Cross Dental Direct Subscriber Agreement, Series C (11/06)

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1.0 INTRODUCTION

1.1 How to Find What *You* Need to Know

The Table of Contents will help *you* find details about covered services as well as other important information about eligibility, how *we* pay for *your* dental care services, dental care services that are not covered under this agreement and how to file and appeal a *claim* when *you* or *your* dental care *provider* does not agree with a benefit decision *we* have made.

1.2 *You* and Blue Cross & Blue Shield of Rhode Island

We, Blue Cross & Blue Shield of Rhode Island, agree to pay for *dentally necessary covered dental care services* listed in this agreement. *We* only cover a service listed in this agreement if *we* determine that it is *dentally necessary*. The term *dentally necessary* is defined in Section 8.0 - Glossary. The term *dentally necessary* does not include all dentally appropriate services.

This agreement provides coverage for dental care services that *we* have reviewed and determined are eligible for coverage. Dental care services that *we* have not reviewed or that *we* have reviewed and determined are not eligible for coverage under this agreement are not covered under this agreement. If a service or category of service is not listed as covered it is not covered under this agreement. Section 3.0 lists the dental care services covered under this agreement and Section 5.0 lists services not covered under this agreement.

1.3 Agreement and Its Interpretation

Our entire contract with *you* consists of this agreement. *We* have the right and discretionary authority to determine eligibility for *benefits* and to construe the provisions of this agreement, and any such construction made by *us* in good faith, or any determination made by *us* in good faith with respect to coverage matters is binding upon *you* to the extent that it does not reduce *your* right to appeal or to take legal action as set forth in Section 7.0.

This agreement may be changed by *us.* If this agreement changes, *we* will issue an amendment or new agreement signed by *our* President and Chairman of the Board of Directors. *We* will mail or deliver written notice of any change to *you.*

This agreement shall be construed under and shall be governed by the applicable laws and regulations of the State of Rhode Island as amended from time to time.

1.4 Words With Special Meaning

Some words and phrases used in this agreement are in italics. This means that the words/phrases have a special meaning as they relate to *your* dental care coverage. The glossary at the end of this agreement defines many of these words. Other

sections of this agreement that also contain definitions of certain words and phrases are Section 6.0 which describes how *we* coordinate *benefits* when *you* are covered by more than one *plan* and Section 7.0 which addresses *your* right to appeal a decision *we* make.

1.5 General Information

If *you* have questions or issues regarding *your* dental benefits as described under this agreement, call the Customer Service Department. *Our* customer service representatives are available to answer *your* questions, Monday - Friday, 8:15 a.m. - 7:00 p.m. and Saturday 9:00 a.m. to 2:00 p.m. When *you* call, identify yourself as a Blue Cross *dental subscriber* and have *your* 13-digit *subscriber* identification number ready. Below are a few examples of when *you* can call customer service:

- To learn if a *dentist* participates with Blue Cross Dental, call the Customer Service Department at (401) 831-7300 or 1-800-527-7290.

- To file a complaint, call the Customer Service Department at (401) 831-7300 or 1-800-527-7290.

- To find out how to file a written appeal or learn about the status of *your* appeal process, call the Customer Service Department at (401) 831-7300 or 1-800-527-7290.

- To obtain *pre-authorization* guidelines for covered dental services provided by a *non-network dentist, you* or *your dentist* can call (401) 453-4700 or 1-800-831-2400 prior to receiving care. Lines are open Monday - Friday, 8:15 a.m. – 4:30 p.m.

To find out all the latest Blue Cross & Blue Shield of Rhode Island news and *plan* information, visit *our* web site at www.bcbsri.com.

1.6 *Your* Right To Choose *Your* Own *Dentist*

Your relationship with *your dentist* is very important. This agreement is intended to encourage the relationship between *you* and *your dentist*. However, *we* are neither obligated to provide *you* with a *dentist*, nor are *we* liable for anything *your dentist* does or does not do. *We* are not a dental care provider and *we* do not practice dentistry, furnish dental care or make dental judgments. *We* review claims for payment to determine whether claims were properly authorized, constitute *dentally necessary* services for the purpose of benefit payment, and are covered dental services under this *plan*. The determination by *us* of whether a service is *dentally necessary* is solely for the purpose of claims payment and the administration of dental benefits under this *plan*; the determination is not an exercise of professional dental judgment.

1.7 *Our* Right to Receive and Release Information About *You*

We are committed to maintaining the confidentiality of *your* health care information.

However, for *us* to make available quality, cost-effective dental care coverage to *you*, *we* may release and receive information about *your* health, treatment, and/or condition to or from authorized *dentists* and insurance companies, among others. *We* may release or receive this information as permitted by law for certain purposes, including, but not limited to:

- adjudicating health insurance *claims;*
- administration of *claim* payments;
- health care operations;
- *utilization review;* AND
- coordination of health care benefits provided.

Our release of information about *you* is regulated by law. For more information, please see the Rhode Island Confidentiality of Health Care Communications and Information Act, §§ 5-37.3-1 et seq. of the Rhode Island General Laws, the Gramm-Leach-Bliley Financial Modernization Act, 15 U.S.C. §§ 6801-6908, and Regulation 100 adopted by the Rhode Island Department of Business Regulation. Federal regulations governing the confidentiality of health related information are scheduled to go into effect in April 2003, which will also govern *our* treatment of information about *you* after that date. See 45 C.F.R. §§ 160.101 et seq.

1.8 *Our* Right to Conduct Utilization Review

To ensure a *member* receives appropriate *benefits*, *we* reserve the right to conduct *utilization review* or to contract with an organization to conduct *utilization review* on *our* behalf. If another company performs *utilization review* on *our* behalf, such company will act as an independent contractor and not a partner, agent, or employee of Blue Cross & Blue Shield of Rhode Island. This agreement provides coverage for only *dentally necessary* care. The determination by an entity conducting *utilization review* of whether a service is *dentally necessary* is solely for the purpose of *claims* payment and the administration of *your* dental benefit *plan*, and is not a professional dental judgment. Although *we* may conduct *utilization review*, Blue Cross & Blue Shield of Rhode Island does not act in the capacity of a dental care *provider*, does not furnish dental care and does not make dental judgments. *You* are not prohibited from undergoing a treatment for which reimbursement has been denied, and nothing herein shall alter or affect *your* relationship with *your dentist(s)*.

2.0 ELIGIBILITY

2.1 Who is Eligible for Coverage

You*: You* are eligible to enroll during an open enrollment period for coverage under this agreement if:

- *you* reside in Rhode Island;
- *you* are not eligible for an employer-sponsored group dental coverage or *plan*;
- you are not enrolled in any other *plan* that includes dental coverage such as, but not limited to, Medicare Advantage, TRICARE, or similar federal programs;
- *you* have exhausted any *COBRA* benefit available to *you*.

Your **spouse**: only one of the following persons can be considered eligible to enroll under family coverage with *you* at the same time:

- Spouse: *Your* lawful spouse, according to the statutes of the state in which *you* were married, is eligible to enroll for coverage under this agreement.
- Former Spouse: In the event of a divorce, *your* former spouse will continue to be eligible for dental coverage provided that *your* divorce decree requires *you* to maintain continuing dental coverage under a family policy in accordance with state law. In that case, *your* former spouse will remain eligible on *your* policy until the earlier of the date either *you* or *your* former spouse are remarried, the divorce agreement changes, or until *your* former spouse has comparable coverage available through his or her own employment.
- Common Law Spouse: *Your* spouse by common law of the opposite gender is eligible to enroll for coverage under this agreement if *you* and *your* Common Law Spouse complete and sign *our* Affidavit of Common Law Marriage and *we* receive the necessary proof, as determined by *us*.

Your **Children:** Each of *your* unmarried children are eligible for coverage until January 1st following their nineteenth (19th) birthday, or as ordered by a Qualified Medical Child Support Order ("QMCSO"). For purposes of determining eligibility under this agreement, the term Child means:

- Natural Children
- Step-Children
- Legally-Adopted Children: An adopted child will be considered eligible for coverage as of the date of placement for adoption with *you* by a licensed child placement agency.
- Foster Children: *Your* foster children who permanently reside in *your* household are eligible to enroll for coverage under this agreement.

You **must provide satisfactory proof as determined by *us* to enroll *your* adopted children, step-children, foster children, or children who will be considered**

eligible due to a QMCSO.

When a child who is enrolled for coverage under this agreement reaches age nineteen (19) and is no longer considered eligible for coverage, *your* child's eligibility may be continued if the child is a disabled dependent:

- Disabled Dependents: If *you* have an unmarried child who is medically certified as disabled and is chiefly dependent on *you* for support and care because of mental impairment or physical disability, that child may be an eligible dependent under this agreement.

  If *you* have a child whom *you* believe satisfies these conditions, *you* must call *us* to obtain a special application for continued coverage. In the application, *you* must show proof of the disability. Periodically thereafter, *you* may be asked to show proof that this disabling condition still exists to maintain coverage as a dependent for this child.

2.2 When *Your* Coverage Begins

This agreement goes into effect on the first day of the calendar quarter following the date *we* accept your application during open enrollment and *you* have paid *our* membership fees. This agreement will remain in effect until its anniversary date and will be automatically renewed as long as *your* membership fees are paid.

Open Enrollment: An open enrollment period will be held four times per calendar year for coverage to begin on the first day of January, April, July, or October. *You* and/or *your* eligible dependents may enroll by making written application during the open enrollment period. **If *your* dependents fail to enroll at this time, they cannot enroll in the *plan* until *our* next open enrollment period unless *you* experience a change in family status or your dependents experience a loss of coverage as described below:**

- Change in family status: *Your* eligible dependents may enroll outside the open enrollment periods if *you* get married or have a child born to or placed for adoption in *your* family.
- Loss of Coverage: *Your* eligible dependents may enroll outside the open enrollment periods if they experience a loss of coverage that meets each of the following conditions:

  a) The eligible dependent seeking coverage had other coverage at the time that he or she was first eligible for coverage under this agreement;

  b) The dependent waived coverage under this plan due to being covered on another plan; and

  c) The coverage on the other plan is terminated as a result of loss of eligibility for the coverage.

2.3 When *Your* Coverage Changes

How to Add or Delete Family Members

You must notify *us* if *you* want to add family members according to the provisions described in Section 2.2.

You must notify *us* if *you* want to remove family members from *your* coverage. *You* must send notification to *us* and *we* will remove family members effective the first day of the month following the month in which notification was received. *We* must receive notice to remove *your* family members at least five (5) working days prior to the requested date of removal. If *we* do not receive *your* notice within this five (5) working day period, *you* will be responsible for furnishing payment to *us* for another month's membership fees. Requests for retroactive removal of family members will **NOT** be allowed.

2.4 When *Your* Coverage Ends

When *We* End This Agreement

This agreement will end automatically:

(a) on the date membership fees due are not paid;
(b) the first day of the month following that month in which *you* cease to be an eligible member or dependent; OR
(c) the date fraud is determined by *us*. Fraud includes, but is not limited to, misuse of *your* identification card and any misrepresentation made by *you* or on *your* behalf that affects *your* coverage. Fraud may result in retroactive termination, and *you* will be responsible for all costs incurred by Blue Cross & Blue Shield of Rhode Island as a result of the fraud. Furthermore, Blue Cross & Blue Shield of Rhode Island at its discretion may decline *your* reinstatement or any other coverage that may become available in the future; OR
(d) the date abuse or disregard for dentist protocols and policies is determined by *us*. If after making a reasonable effort *dentists* are unable to establish or maintain a satisfactory relationship with a *member*, coverage may be terminated after 31-days' written notice. Examples of unsatisfactory *dentist*-patient relationships include abusive or disruptive behavior in a *dentist's* office, repeated refusals by a *member* to accept procedures or treatment recommended by a *dentist*, and impairing the ability of the *dentist* to provide care; OR
(e) if *we* cease to offer this type of coverage.

Reinstatement

We may reinstate coverage under this agreement at *our* discretion if *you* make written application to *us* and pay any required premiums within forty-five (45) days of the premium due date. Required premiums include any overdue premiums and any

premiums currently billed.

If *your* coverage is terminated under this agreement, twelve (12) months from the cancellation date must pass before you may re-apply for coverage. If *we* approve *your* application and collect required premiums due, *your* coverage will resume on the effective date of the next open enrollment period.

If *you* cancel your coverage under this agreement and reinstate later, a **new** twelve (12)-month *waiting period* must pass before benefits become available for covered services described in Sections 3.16 and 3.17.

When *You* End This Agreement

You may end this agreement by notifying *us* that *you* want to discontinue coverage or by not paying *your* membership fees.

We must receive *your* notice to end this agreement at least five (5) working days prior to the requested date of cancellation. If *we* do not receive *your* notice within this five (5) day period, *you* will be responsible for another month's membership fees. Requests for retroactive cancellations will NOT be allowed.

3.0 COVERED SERVICES

We cover the following services when rendered by a *dentist* (See Section 8.0 - Glossary for definition of *dentist*). **All covered services are subject to the provisions below.**

We will NOT cover *multi-stage procedures* that **STARTED** before the effective date of this agreement even if those procedures are completed after the effective date of this agreement and even if they are covered services under this agreement. *We* will **NOT** cover multi-stage procedures that **STARTED** during the twelve (12)-month *waiting period* that must pass before benefits become available for crowns, inlays/onlays, and surgical periodontics (see Sections 3.16 and 3.17).

3.1 *Annual Maximum Benefit, Deductible,* and *Copayment/Coinsurance* Amounts

The maximum amount *we* pay for covered services is $1000 per member per calendar year.

There is no annual deductible amount applied to covered services under this agreement.

All Basic Services from *network dentists* are covered up to one hundred percent (100%) of *our allowance*. If the *dentist* is *non-network, you* are responsible for paying the full charge and *we* will reimburse *you* up to one hundred percent (100%) of *our allowance.*

All Minor Restorative Services are covered up to eighty percent (80%) of *our allowance* when the *dentist* is a *network dentist*. If the *dentist* is a *non-network dentist, you* are responsible for paying the full charge and *we* will reimburse *you* up to eighty percent (80%) of *our allowance*.

All Major Restorative Services are covered up to fifty percent (50%) of *our allowance* when the *dentist* is a *network dentist.* If the *dentist* is a *non-network dentist*, *you* are responsible for paying the full charge and *we* will reimburse *you* up to fifty percent (50%) of *our allowance.* **Members must be enrolled in the Plan for twelve (12) months before benefits for major restorative services become available. If *you* end this agreement and re-enroll later, a new twelve (12)-month *waiting period* must pass before benefits for major restorative service become available. See the reinstatement information in Section 2.4 and the definition of *waiting period* in the Glossary (section 8.0).**

BASIC SERVICES:

3.2 Oral Examinations

We cover one (1) initial or periodic routine oral examination per calendar year, including diagnosis and charting, when a general dentist performs the exam.

This agreement does NOT cover oral examinations (limited in scope) performed by a

dentist who limits his/her practice to a specialty branch of dentistry. See section 5.7 for details.

3.3 X-Rays

We cover one (1) bitewing series per calendar year.

We cover one (1) full mouth set of x-rays (including bitewings), intraoral or panoramic, every sixty (60) months.

Individual x-rays are covered as needed.

3.4 Cleanings

We cover up to two (2) cleanings per calendar year, including scaling and polishing.

3.5 Fluoride Treatments

For eligible subscribers under the age of 19, *we* cover one (1) topical application of fluoride (one treatment technique or its equivalent) per calendar year.

MINOR RESTORATIVE SERVICES:

3.6 Biopsies

Covered biopsies are limited to the biopsy and examination of hard or soft oral tissue.

3.7 Minor Treatment for Acute Dental Pain

We cover minor treatment to reduce or relieve acute dental pain when necessary.

3.8 Fillings

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 for paying any difference between *our allowance* for amalgam fillings and the *dentist's* charge. Other restorative services covered include recementing of crowns or inlays/onlays.

3.9 Extractions

We cover the simple extraction of an erupted tooth that does not require a surgical procedure.

3.10 Sealant Treatments

Sealant treatments on permanent molars, with no prior restoration on the occlusal surface, are covered for subscribers between the ages of six (6) through thirteen (13). Coverage is limited to one (1) sealant treatment per three (3) year period.

3.11 Space Maintainers

We cover space maintainers that are NOT made of cast precious metals.

3.12 Oral Surgery

Surgical extractions and other oral surgical procedures that *we* have approved are covered only when oral surgery is not a covered service under any medical or surgical insurance *plan*. General anesthesia is covered only when rendered in conjunction with a covered oral surgical procedure.

3.13 Root Canal Therapy (Endodontics)

We cover root canal therapy procedures for all permanent teeth, excluding final restoration. *We* cover vital pulpotomy for subscribers under the age of 11.

3.14 Denture Repairs

We cover services to repair broken dentures, including replacement of teeth and reattachment or replacement of clasps or facings. Coverage of relining or rebasing of full or partial dentures by a lab is limited to once every five (5) years.

3.15 Non-Surgical Periodontics

Pre-authorization is recommended for this service. See the definition of *pre-authorization* in Section 8.0.

Periodontic maintenance following documented periodontal surgery is covered up to two (2) times per calendar year if at least three (3) months have passed since the completion of active periodontal surgery.

Periodontal scaling and root planing is covered up to one (1) time per twenty-four (24)-month period per quadrant.

MAJOR RESTORATIVE SERVICES:

3.16 Crowns, Inlays/Onlays

Pre-authorization is recommended for this service. See the definition of *pre-authorization* in Section 8.0.

This agreement covers crowns and inlays/onlays to restore natural teeth. Crowns and inlays/onlays that are not part of a fixed bridge are covered. Replacements will be covered only if the existing crown, inlay/onlay is more than five (5) years old, is not servicable, and cannot be repaired.

Waiting Period: *You* must be enrolled in the *plan* for twelve (12) months before benefits become available for crowns and inlays/onlays. If *you* cancel *your* coverage under this agreement and reinstate later, a new twelve (12)-month *waiting period* must pass before benefits become available for these services.

We will NOT cover crowns and inlays/onlays that **STARTED** before the effective date of this agreement. *We* will NOT cover crowns and inlays/onlays that **STARTED** during the twelve (12)-month *waiting period* that must pass before benefits become available for these services.

3.17 Surgical Periodontics

Pre-authorization is recommended for this service. See the definition of *pre-authorization* in Section 8.0.

This agreement covers services and surgical procedures for the treatment of tissues supporting the teeth.

Waiting Period: *You* must be enrolled in the *plan* for twelve (12) months before benefits become available for surgical periodontics. If *you* cancel *your* coverage under this agreement and reinstate later, a new twelve (12)-month *waiting period* must pass before benefits become available for these services.

We will NOT cover surgical periodontic services that **STARTED** before the effective date of this agreement. *We* will NOT cover surgical periodontic services that **STARTED** during the twelve (12)-month *waiting period* that must pass before benefits become available for these services.

4.0 HOW *WE* PAY FOR *YOUR* COVERED DENTAL CARE SERVICES

Payments *we* make to *you* are personal, and *you* cannot transfer or assign any of *your* right to receive payments under this agreement to another person or organization.

If more than one *dentist* renders services for one dental procedure, *we* will not be responsible for more than *our allowance* for treatment when performed by one *dentist*. If there are optional treatment techniques and each has a different *allowance*, *we* will use *our allowance* for the treatment with the lesser *allowance*.

4.1 How *We* Pay *Network Dentists*

We pay *network dentists* directly for covered dental care services. *You* are responsible for payment of *copayments/coinsurance* (if any) applicable to a *covered dental care service*. *Network dentists* agree not to bill, charge, collect a deposit from, or in any way, seek reimbursement from *you* for a *covered dental care service*, except for the *copayments/coinsurance* that may apply to a *covered dental care service*.

4.2 How *We* Pay *Non-Network Dentists*

You are responsible for paying all *charges* from a *non-network dentist*. *We* reimburse *you our allowance*, less any *copayments/coinsurance* that may apply to a *covered dental care service* or procedure. *Our* reimbursement for *non-network dentist* services will never be more than the amount *we* pay for *network dentist* services. See Section 8.0 for the definition of *our allowance*.

5.0 SERVICES NOT COVERED UNDER THIS AGREEMENT

5.1 Services Not Listed in Section 3.0

This agreement does NOT cover any service that is not specifically listed in Section 3.0, Covered Services.

5.2 Anesthesia

General anesthesia (intravenous or inhalation) is NOT covered unless it's rendered in conjunction with a covered oral surgical procedure. This agreement does NOT cover the services of an anesthesiologist.

5.3 Benefits Available From Other Sources

This agreement does NOT cover services when there is no *charge* to *you*. *We* will not cover services when *you* can recover the cost through a Federal, State, county or municipal law or through legal actions. This agreement does NOT cover services available to *you* in whole or in part, under any Workers' Compensation Law or similar legislation. These services are NOT covered whether or not *you* choose or fail to assert *your* rights under these laws.

This agreement does NOT cover services received from a dental or medical department maintained or on behalf of an employer, mutual benefit association, labor union, trustee, or similar group or person.

5.4 Cosmetic Services

Services performed only to change or improve *your* appearance are NOT covered.

5.5 Drugs

Injectable or prescription drugs are NOT covered.

5.6 New or Experimental/Investigational Services and Services That *We* Have Not Approved

This agreement does NOT cover new, experimental and/or investigational procedures, or services or services, supplies, or procedures, that have not been approved by *us*.

5.7 Specialty Oral Examinations

This agreement does NOT cover oral examinations (limited in scope) when performed by a *dentist* who limits his/her practice to a specialty branch of dentistry. This includes, but is not limited to, oral examinations relating to periodontics, orthodontics, endodontics, oral surgery, and prosthodontics.

5.8 Replacement Services

This agreement does NOT cover orthodontic or prosthetic appliances or space maintainers that are misplaced, lost, or stolen.

5.9 Services Performed By Hospital Staff Employees

This agreement does NOT cover dental services rendered at a hospital by interns, residents, or staff *dentists*.

5.10 Services Performed Prior To The Effective Date

Services rendered or devices provided prior to the effective date of this agreement are NOT covered.

We will NOT cover *multi-stage procedures* **STARTED** before the effective date of this agreement even if those procedures are completed after the effective date of this agreement and even if they are covered services under this agreement.

5.11 Services That Are Not Dentally Necessary

Services that *we* determine are not *dentally necessary* for the diagnosis, treatment, or prevention of dental disease are NOT covered.

5.12 Services for or Related to Treatment of Temporomandibular Joint Dysfunction (TMJ)

This agreement does NOT cover appliances or restorations necessary to increase vertical dimensions or to restore the occlusion, including all services for or related to the treatment of Temporomandibular Joint Dysfunction (TMJ).

5.13 Travel Expenses

Travel expenses or other related expenses that may be incurred by a *dentist* providing services are NOT covered.

5.14 Veneers

This agreement does NOT cover veneers (bonding of coverings to the teeth).

5.15 Implants

This agreement does NOT cover dental implants.

6.0 HOW *WE* COORDINATE *YOUR* BENEFITS WHEN *YOU* ARE COVERED BY MORE THAN ONE *PLAN*

Introduction

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

We follow the COB rules of payment issued by the National Association of Insurance Commissioners (NAIC) as adopted by the Rhode Island Department of Business Regulation. From time to time these rules may change prior to issuance of a revised *subscriber* agreement. *We* utilize the regulations concerning COB in effect at the time of coordination to determine benefits available to *you* under this agreement. If *you* have any questions regarding these provisions, please call *our* Customer Service Department at (401) 831-7300 or 1-800-527-7290.

If this provision applies, the order of benefit determination rules determine whether *we* pay dental benefits before or after the dental benefits of another *plan*.

Please note that all services must be *dentally necessary* in order to be covered, regardless of whether *this plan* is the *primary* or *secondary plan*. Services paid by other *plans* will be used when determining any duration or visit limits. When *this plan* is *secondary*, services that in total exceed the duration or visit limits on *this plan* will not be covered unless *dental necessity* is demonstrated.

6.1 Definitions

ALLOWABLE EXPENSE means the necessary, reasonable and customary item of expense for dental care and treatment that is:

(a) covered at least in part under one or more *plans* covering the person for whom the claim is made; AND

(b) incurred while this agreement is in force.

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

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

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

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

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

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

6.2 When *You* Have More Than One Agreement with Blue Cross & Blue Shield of Rhode Island

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

6.3 When *You* Are Covered By More Than One Insurer

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

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

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

(a) whether *you* are the main *subscriber* or a dependent;

(b) if married, whether *you* or *your* spouse was born earlier in the year; OR

(c) length of time each spouse has been covered.

(1.) Non-Dependent/Dependent - If *you* are covered under a *plan* and *you* are the main *subscriber*, the *benefits* of that *plan* will be determined before the *benefits* of a *plan* which covers *you* as a dependent.

(2.) Dependent Child/Parents Not Separated or Divorced - If dependent children are covered under separate *plans* of more than one person (e.g., "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' birthdates, but by parents' gender instead, the other *plan*'*s* gender rule will determine the order of *benefits*.

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

(a) first, the *plan* of the parent with custody of the child;

(b) then, the *plan* of the spouse of the parent with custody of the child; AND

(c) finally, the *plan* of the parent not having custody of the child.

If the terms of a court decree state that one of the parents is responsible for the dental care expenses of the child, and the entity obligated to pay or provide the parent's dental *benefits* under that parent's *plan* has actual knowledge of those terms, the *benefits* of that *plan* are determined first and the dental *benefits* of the *plan* of the other parent are the secondary *plan*.

If the terms of a court decree state that the parents share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in Section 6.3 (2) above.

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

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

Maximum *benefits* paid by first insurer
\+ Any remaining *allowable expense* paid by other insurer
Total *Benefits* Payable

6.4 *Our* Right to Make Payments and Recover Overpayments

If payments that should have been made by *us* according to this provision have actually been made by another organization, *we* have the right, exercisable alone at *our* own discretion, to pay those organizations the amounts *we* decide are necessary to satisfy the rules of this provision. These amounts are considered *benefits* provided under this agreement and *we* are not liable for them.

If *we* have made payments for *allowable expenses* which are more than the maximum

amount needed to satisfy the conditions of this provision, *we* have the right to recover the excess amounts from: the person to or for whom the payments were made; any other insurers; and/or any other organizations (as *we* decide). As the *subscriber*, *you* agree to pay back any excess amount, provide information and assistance, or do whatever is necessary to recover this excess amount. When determining the amount of payments made *we* include the reasonable cash value of any *benefits* provided in the form of services.

7.0 HOW TO FILE AND APPEAL CLAIMS

7.1 How to File a Claim

You must file all claims within ninety (90) days after receiving a covered service. The claim is invalid if you do not provide us with proof that services have been received within that timeframe unless:

(a) *we* determine that it is not reasonably possible for you to provide proof within ninety (90) days; AND

(b) the proof is provided to *us* as soon as possible, and in no event later than one (1) year after it was otherwise required to be filed with *us* (unless you are legally incapable).

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

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

Non-network dentists may or may not file claims for *you*. If the *non-network dentist* does not file the claim on *your* behalf, *you* will need to file the claim *yourself*. To file a claim, please send *us* an itemized bill including the following:

(a) patient's name;

(b) *your* 13-digit *subscriber* identification number;

(c) name and address of the *dentist* who performed the service;

(d) date and description of the service; AND

(e) *charge* for that service.

Please mail your claims to: **Blue Cross & Blue Shield of Rhode Island**
Attention: Blue Cross Dental
P.O. Box 219
Providence, Rhode Island 02901-0219

7.2 Complaint and Administrative Appeal Procedures

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

An **Administrative Appeal** is a verbal or written request for *us* to reconsider a full or partial denial of payment for services that were denied because *we* determined that the services were excluded from coverage or because *you* or *your dentist* did not follow Blue Cross and Blue Shield of Rhode Island's requirements.

How to File a Complaint or Administrative Appeal

If *you* have concerns about any aspect of *your* dental treatment, please call Customer Service at: (401) 831-7300 within Rhode Island or at 1-800-527-7290 outside of Rhode Island. Customer Service will log *your* call and the nature of the issue and attempt to resolve the problem. If Customer Service can't resolve *your* inquiry to *your* satisfaction, *you* may file a *complaint* or an *administrative appeal*. Administrative appeals must be filed within one hundred and eighty (180) days of the initial denial of the claim.

To file a *complaint* or *administrative appeal*, *you* must provide the details of *your complaint* or *administrative appeal* and include the following information:

- name, address, member ID number
- summary of the *complaint* or *administrative appeal*, any previous contact with Blue Cross & Blue Shield of Rhode Island and a brief description of the relief or solution *you* are seeking
- any additional information such as referral forms, *claims* or any other documentation that *you* would like *us* to review
- the date of incident or service
- *your* signature

If *you* wish to file a *complaint* or *administrative appeal*, *you* can call Customer Service at the telephone number listed above. A Customer Service Representative can take *your* verbal *complaint* or *administrative appeal* over the telephone. If *you* wish to file a written *complaint* or *administrative appeal*, *you* can send *us* a letter with the information requested above. If someone is filing a *complaint* or *administrative appeal* on *your* behalf, *you* must send *us* a notice that the person has the authority to receive information from *us* on *your* behalf. *You* must sign this notice.

Please mail this notice to: **Blue Cross & Blue Shield of Rhode Island**
Attention: Blue Cross Dental
P.O. Box 219
Providence, Rhode Island 02901-0219

Blue Cross Dental will conduct a thorough review of *your Complaint* or *Administrative appeal*. In most cases, the combined time from *our* receipt of *your Complaint* or *Administrative appeal* and sending a written decision to *you* will not exceed sixty (60) calendar days. *Your* determination letter from *us* will provide *you* with information regarding *our* determination (decision) and *your* rights to further review if *you* are not satisfied with the outcome of *our* review and determination.
Blue Cross & Blue Shield of Rhode Island does not offer any further internal or

external review, though *you* may notify the State of Rhode Island Department of Health regarding *your* concerns.

7.3 Dental Necessity Appeal Procedures

A ***dental necessity appeal*** is a verbal or written request for *us* to reconsider a full or partial denial of payment for services that were denied because *we* determined one of the following:

- the services were not *dentally necessary*; or
- the services are experimental or investigational.

If *we* deny payment for a service for lack of *dental necessity*, *you* will receive the denial in writing. The written denial *you* receive from *us* will explain the reason for the denial and provide specific instructions for filing a *dental necessity appeal*. *You* are entitled to the following levels of review when seeking a *dental necessity appeal*:

Level 1 Review

You may request a Level 1 review of any matter subject to *dental necessity appeal* by making a request for such review to *us* within one hundred and eighty (180) calendar days of the initial determination letter. *You* may request this review by calling Customer Service, but *we* strongly suggest that *you* submit *your* request in writing to ensure *your* request is accurately reflected.

You will receive notification of the determination on a Level 1 review within fifteen (15) calendar days of receipt of the appeal request. If *you* are requesting reconsideration (Level 1 review) of a service that was denied after *you* already obtained the service (retrospectively), then *you* will receive written notification of *our* determination within thirty (30) calendar days of *our* receipt of the appeal.

Level 2 Review

You may request a Level 2 appeal review (preferably in writing) if *our* denial was upheld during the Level 1 review process. *Your* Level 2 appeal review will be reviewed by a different dentist than the dentist who performed the Level 1 review. *You* must submit *your* request for a Level 2 appeal review within one hundred and eighty (180) calendar days of the date of the reconsideration determination letter. Upon request for a Level 2 review, *we* will provide *you* with the opportunity to inspect the dental file and add information to the file. *You* will receive written notification of a determination on a Level 2 review within fifteen (15) calendar days of receipt of the appeal request. If the service *you* are requesting review of was denied after *you* already obtained the service (retrospectively), *you* will receive written notification of *our* determination within thirty (30) calendar days of receipt of the appeal request.

Note: Y*ou may request an expedited review of denied services if the circumstances are an emergency. Due to the urgent nature of an expedited dental necessity appeal,*

to request an expedited dental necessity appeal you or your dentist must call Blue Cross Dental at 1-800-831-2400. An expedited determination will be made within two (2) business days following receipt of all dental necessity documentation required to conduct the review, but not to exceed a total of seventy-two (72) hours from receipt of the appeal.

External Appeal

If *you* remain dissatisfied with the determination of *our* internal review (Level 1 and Level 2) processes, *you* may request an external review by an outside review agency.

To request an external review *you* must submit *your* request in writing to *us* within 180 calendar days of *your* receipt of the dental necessity appeal denial notification.

- If *you* are appealing a service that was denied because *we* determined that the service was not *dentally necessary*, *you* will select the external appeal agency that will perform the external appeal from a list of Department of Health approved agencies. *You* will be responsible for payment for fifty percent (50%) of the *charges* and fees from the external agency and *we* will pay the remaining fifty percent (50%). However, if the external appeal agency overturns *our* denial determination, *we* will reimburse *you* for *your* half of the cost of the review. For all non-*emergency* appeals, the external appeal agency will notify *you* of its determination within ten (10) business days of the agency's receipt of the information. For all *emergency* external appeals, the external appeals agency will notify *you* of its determination within two (2) business days of the agency's receipt of the information.
- If *you* are appealing a service that was denied because *we* determined that the service was *experimental/investigational*, *your* appeal will be reviewed by an agency contracted with *us*. *We* will pay for the entire cost for the review. For all non-*emergency* appeals, *we* will notify *you* of the external appeal agency's determination within twenty (20) business days. For all *emergency* external appeals, *we* will notify *you* of the external appeal agency's determination within five (5) business days.

Judicial Review

If *you* are dissatisfied with the final decision of the external appeal agency, *you* are entitled to a final review (a Judicial Review). This review will take place in an appropriate court of law.

Note: Once a member or dentist receives a decision at one of the several levels of appeal (Level 1, Level 2, External, and Judicial), the dentist or member may not ask for an appeal at the same level again, unless additional information that could impact such decisions can be provided.

7.4 Grievances Unrelated to Claims

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

You may also access *our complaint* and grievance procedures if *you* have a *complaint* about *our* service or regarding one of *our* employees. In order to initiate a grievance, please call *our* Customer Service Department at (401) 831-7300 or 1-800-527-7290. The Customer Service Department will log in *your* call and begin working towards the resolution of *your complaint*.

The grievance procedures described in this Section 7.4 do not apply to dental necessity determinations (addressed in Section 7.3), *complaints* regarding payments (addressed in Section 7.2), *claims* of dental malpractice or to allegations that *we* are liable for the professional negligence of any *dentist* furnishing services under this agreement.

7.5 Legal Action

You cannot recover payment for a *claim* through legal actions unless *you* notify *us* in writing that *you* intend to take action against *us*.

You may begin court proceedings within sixty (60) days after the date *you* filed *your claim*. In no event may legal action be taken against *us* later than three (3) years from the date *you* were required to file the *claim* (see Section 7.1).

7.6 *Our* Right To Withhold Payments

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

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

7.7 Subrogation

In the event that any benefit is provided for, or any payment is made or credit extended, to a *subscriber* under this agreement, Blue Cross & Blue Shield of Rhode Island shall be subrogated and shall succeed to the *subscriber's* right of recovery

against any party, including such individual's *employer/agent*, alleged to be legally responsible for the *subscriber*. This right of *subrogation* extends to uninsured and underinsured motorist clauses and no-fault insurance policies. This Section 7.7 does not affect the order of determination of benefits under any applicable Coordination of Benefits provision.

The *subscriber* acknowledges that Blue Cross & Blue Shield of Rhode Island's *subrogation* rights shall be considered as a first priority *claim* against any party to be paid before any other *claims*, including *claims* for compensatory and/or punitive damages by the *subscriber*. The *subscriber* shall take such action, furnish such information and assistance, and execute such assignments and other instruments as *we* may require to facilitate enforcement of *our* rights hereunder, and shall take no action prejudicing the rights and interests of Blue Cross & Blue Shield of Rhode Island. *We* may take such action as may be necessary and appropriate to preserve *our* rights under this *subrogation* provision. *We* may collect, at *our* option, any and all amounts from the proceeds of any settlement of judgment that may be recovered by such *subscriber*, or such *subscriber's* legal representative. Any proceeds of settlement or judgment shall be held in trust by the *subscriber* for *our* benefit under this *subrogation* provision, and *we* shall be entitled to recover reasonable attorneys' fees from such *subscriber* incurred in collecting proceeds from such individual. In the event that there is a court-ordered distribution of funds, *we* must be notified as soon as possible and given a reasonable time to respond before such distribution takes place. *Our subrogation* rights under this Section 7.7 are enforceable to the extent permitted by Rhode Island law.

8.0 GLOSSARY

ANNUAL MAXIMUM BENEFIT means the total amount *we* pay per *subscriber* per calendar year for covered dental services under this agreement.

CHARGES means the usual and customary amount billed by any *dentist* for covered dental services without the application of any discount or negotiated fee arrangement.

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

COPAYMENT/(COINSURANCE) means the portion or percentage of *Our Allowance* that *you* must pay for covered dental services. See definition of *Our Allowance.*

DATE STARTED or STARTED means the date *we* use to determine when a single or multi-stage covered service or procedure begins.

DATE COMPLETED or COMPLETED means the date *we* use to determine when a single or *multi-stage* covered service or procedure is complete.

DEDUCTIBLE means the amount that you must pay for covered services before *we* provide maximum benefits under this agreement. There is no annual deductible for services provided under this agreement. See Section 3.1, *Annual Maximum Benefit, Deductible, and Copayment/Coinsurance* Amounts.

DENTALLY NECESSARY (DENTAL NECESSITY) means that the dental services provided to *you* are necessary, appropriate and cannot be performed in a more cost-effective manner. Dental services must be required for reasons other than *your* convenience or the convenience of *your dentist*.

We determine *dental necessity* on a case-by-case basis. *We* may establish *pre-authorization* techniques and apply administrative policies as *we* deem reasonable and/or necessary in approving the eligibility of *subscribers* as well as the appropriateness of treatment plans and related *charges*.

We, not *your dentist*, determine *dental necessity*. The fact that *your dentist* performed or prescribed a procedure does not mean that it is *dentally necessary*.

DENTIST means any person duly licensed and registered to practice dentistry as defined in Section 5-31-1 of the General Laws of Rhode Island, as amended. This includes persons duly licensed under comparable laws of other states and countries if covered services are rendered at the time and place that comparable laws are effective and the services are performed within the scope of the individual's license.

ELIGIBLE PERSON - Please see Section 2.1 for a detailed description of who is

eligible to enroll as a dependent under this agreement.

MULTI-STAGE PROCEDURE means any procedure that we determine requires more than one office visit to complete including, but not limited to, endodontic or crown procedures.

NETWORK DENTIST means any *dentist* who has signed an agreement with *us* to accept *our allowance* for covered services.

NON-NETWORK DENTIST means any *dentist* who has not signed an agreement with *us* to accept *our allowance* for services covered under this agreement.

OUR ALLOWANCE or **ALLOWANCE** means the maximum amount *we* would pay to a *network dentist* for a covered service or procedure or to you for covered services you receive from a non-network dentist. *Our allowance* for covered dental care services may include payment for other related services. *Your copayments/coinsurance* to *network dentists*, if any, are based on *our allowance*. The amount *we* actually pay for covered dental care services is *our allowance*, less any *copayments/coinsurance. You* are responsible for paying a *non-network dentist's* full charge. Any required copayments/coinsurance will be applied to the allowance before *we* reimburse *you*. The total payments *you* receive will never be more than the cost of the services *you* receive.

If more than one dentist renders services for one dental procedure, *we* will not be responsible for more than *our allowance* for treatment when performed by one dentist. If there are optional treatment techniques and each has a different *allowance*, *we* will use *our allowance* for the treatment with the lesser *allowance*.

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

PRE-AUTHORIZATION is the approval that *we* recommend *you* obtain prior to receiving a covered dental care service so that *we* can review and determine the *dental necessity* of a service. **Pre-authorization is not a guarantee of payment, as the process does not take benefit limits into account.** *Network dentists* are responsible for obtaining *pre-authorization* for all applicable covered dental care services.

When the *dentist* is non-network, *you* are responsible for obtaining *pre-authorization*. **If you do not obtain pre-authorization and services are determined to be not dentally necessary upon retrospective review, your claim will be denied.** *You* may inquire about *pre-authorization* by telephoning *us* at (401) 453-4700 or 1-800-831-2400.

Pre-authorization is recommended for each of the following services. See Section 3.0,

Covered Services, for details.

(a) crowns and inlays/onlays; AND
(b) periodontics (treatment of gums).

SUBROGATION means that a third person or entity assumes the legal right of another person or entity to collect a debt or damages. See Section 7.7, Subrogation.

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

UTILIZATION REVIEW means the *prospective* (prior to) and *retrospective* (after) assessment of the necessity and appropriateness of any service given or proposed to be given to a *subscriber*.

- **Prospective Review** is a review conducted prior to the receipt of services.
- **Retrospective Review** is a review conducted after services have been rendered.

YOU and YOUR means the *subscriber* who has applied for the benefits described in this agreement and whose application has been approved by *us*.

WAITING PERIOD or TWELVE (12)-MONTH WAITING PERIOD means the twelve (12) months during which *you* must be enrolled in the *plan* before benefits become available for covered major restorative services including crowns, inlays/onlays, and surgical periodontics. If *you* cancel *your* coverage under this agreement and reinstate later, a **new** twelve (12)-month *waiting period* must pass before benefits become available for covered major restorative services.

WE, OUR, and US means Blue Cross & Blue Shield of Rhode Island. *We* are located at 444 Westminster Street, Providence, Rhode Island, 02903.

444 Westminster Street
Providence, RI 02903
Tel.: (401) 831-7300
1-800-527-7290

(11/06)