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

BLUE CROSS DENTAL DIRECT

BLUE CROSS & BLUE SHIELD OF RI
January 1, 2016

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 2016

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.health.ri.gov/publications/guides/ConsumersGuideToHealthPlansInRhodeIsland.pdf.

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, Office of Managed Care 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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Blue Cross & Blue Shield of Rhode Island
Customer Service Department
500 Exchange Street
Providence, RI 02903 - 2699

Toll-free 1-800-831-2400; Telephone 401-453-4700
TDD Number 711; 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 1-800-831-2400

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.

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Covered dental services are listed in your official plan document. We recommend predetermination for crowns, onlays, surgical and non-surgical periodontics (treatment of gums), and medically necessary orthodontics for members under 19. If you receive services from a participating dentist, the dentist will be responsible for obtaining predetermination 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 an external appeal. An external appeal is reviewed by an agency that is not affiliated with us. An expedited appeal process is available if the circumstances are urgent or you are in an inpatient setting, which will be decided within 72 hours or two business days, whichever is shorter.

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.

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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.

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Members may seek services from any dental provider without a referral. If the member chooses a non-participating provider, the member will be responsible for the difference between the provider's charge and the Plan's allowance.

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. If a member seeks a second opinion, the Plan will reimburse any eligible covered services up to the Plan's maximum or benefit limitation.

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.

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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.

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> 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.

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> 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.

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

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

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> This Health Plan renews automatically on January 1st of each calendar year as long as the membership fees are paid. Your coverage may be canceled on the date membership fees are not paid, the first day of the month following that month in which you cease to be an eligible person, the first day of the month following that month in which you are no longer a Rhode Island resident, the date you commit fraud, the date you abuse or disregard provider protocols and policies, or if we cease to offer 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.

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This Health Plan will ask if you are the main subscriber or a dependent, your marital status, birth date (for you/your spouse), length of time covered; if you are a Medicare beneficiary; or if you are an active or inactive employee. We may also ask for other information needed 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

The chart below will help you choose the coverage and benefits that meet your needs.

2016 Blue Cross Dental Direct Plans*

BENEFITS	Standard	Elite	Plus	Basic
Calendar Year Maximum (resets every Jan. 1)	$1,000	$2,000	$1,500	$1,000
Deductible	No deductible	$50	No deductible	No deductible
Dependent Coverage	26	26	26	26
Diagnostic and Preventive Services				
Oral exam, bitewing X-rays, complete X-ray series, single X-rays, cleanings, fluoride treatments, and sealants	100%	100%	100%	100%
Space maintainers	Not Covered	Not Covered	Not Covered	Not Covered
Basic Services				
Fillings, palliative treatment, repairs to existing partial or complete dentures, rebasing or relining of dentures, and simple extractions	50%-60%	80%-100%	50%-100%	50% or Not Covered
Recementing crowns or bridges	50%-60%	80%-100%	50%-100%	50% or Not Covered
Major Restorative Services*				
Crowns over natural teeth, build ups, and post and cores	Not Covered	50%	50%	Not Covered
Endodontic Services				
Root canal therapy	60%	80%	50%	Not Covered
Non–Surgical Periodontal Services				
Periodontal maintenance following active therapy, scaling and root planing	50%	50%	50%	Not Covered
Surgical Periodontal Services*				
Osseous (surgery), soft tissue grafts, crown lengthening, and guided tissue regeneration	Not Covered	50%	50%	Not Covered
Prosthodontic Services*				
Bridges, build ups, posts and cores with a fixed bridge, partial and complete dentures, and single tooth implant(in lieu of a 3 unit bridge	Not Covered	50%	50%	Not Covered
Oral Surgery Services				
Extractions and other routine oral surgery when not covered by your medical plan, general anesthesia or intravenous sedation for certain procedures	60%	80%	50%	Not Covered
Oral Appliances				
Night guards	50%	50%	50%	50%

***Pediatric dental services are covered based on guidelines per PPACA.**