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

BLUE CROSS DENTAL

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
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, and surgical and non-surgical periodontics (treatment of gums), prosthodontics (bridges and dentures), implants, occlusal guards and orthodontics (braces) (if covered services under your plan) 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 decision within 180 days of receipt of the determination. We will review your appeal and respond to you within 15 days of receipt of all necessary information. If your appeal is denied, you may request a second appeal under the same terms. If your second appeal is denied, you may request an external appeal. An external appeal is performed 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.

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.

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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 Dental Plan renews automatically on its calendar anniversary date 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 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; and 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

Plus Dental | Blue Cross Dental

Understanding Your Benefits

Standard Provisions

- **Deductibles**

You pay the following amounts each year before your health plan starts to pay toward the cost of covered services:

- **$50 per individual (dependents under age 19)**

- **In Network Calendar Year Maximum**

The following is the calendar the dental plan would pay each year:

For Dependents Under Age 19:

- **No maximum**

For Dependents Over Age 19:

- **$1,500 - per member**

- **In Network Out-of-pocket Limits**

The following is the maximum you would pay out of pocket each year:

For Dependents Under Age 19:

- **$350 for individual plan**
- **$700 per family plan**

Out-of-Network Coverage

When you visit out-of-network dentists you are still covered. Payment to the provider will be based on your plan's reimbursement allowance, less any applicable coinsurance and/or deductible. Please refer to the Blue Cross Dental Subscriber Agreement for specific details.

Service	What You Pay		Description
	Under Age 19	Over Age 19	
Diagnostic and Preventive – Deductible does not apply to these services			
Oral Exams	0%	0%	**Under age 19:** Two routine or emergency oral examinations performed by a general dentist per calendar year. **Over age 19:** One routine or emergency oral examination performed by a general dentist per calendar year.
Cleanings	0%	0%	Two cleanings per benefit year.
Fluoride Treatment	0%	N/C	Two fluoride treatments for members under age 19, per calendar year.
X-rays	0%	0%	Bitewing X-rays – Two sets per benefit year for members up to age 19. One set per 18 month period for members age 19 and older. Full Series or Panoramic X-rays – One set per 60 months. Individual X-rays – Four per calendar year.
Sealants	0%	N/C	One sealant treatment per permanent molar for members under age 19, every 36 months.
Space Maintainers	0%	N/C	Applies only to members under age 14.
Palliative Treatment	20%	0%	Minor treatment to relieve sudden, intense pain.
Basic Dental - Under age 19, deductible applies to these services			
Fillings	50%	20%	Amalgam (silver fillings) – all teeth; composite (white fillings) on front teeth only. Limited to replacement 24 months after original filling is placed. For composite fillings on posterior (back) teeth, the plan pays the amalgam benefit allowance only, and the member is responsible for the difference in payment up to the dentist's charge.
Simple Extractions	50%	20%	Removal of an erupted tooth not requiring surgery.
Denture Repairs	50%	50%	Rebasing and relining covered once every 36 months.

continued

Blue Cross Dental Small Group Top Certified Plans

Blue Cross Dental FlexChoice Plans	FlexChoice Certified 302C (age 19 and over)	PEDI BENEFITS (up to age 19)	FlexChoice Certified 900C (age 19 and over)	PEDI BENEFITS (up to age 19)
Contract Year Deductible Options (per person/per family)	$50/$150	$50/$150	$0/$0	$0/$0
OOP (Up to age 19 only)	N/A	$350/$700	N/A	$350/$700
Annual Maximum Per Member Options (Ages 19 + only)	$1,200	N/A	$1,200	N/A
Built-in Benefits	N/A	N/A	N/A	N/A
Preventive and Diagnostic				
Exams	100%	100%	100%	100%
X-Rays				
Cleanings				
Fluoride Treatments	Not Covered		Not Covered	
Sealants				
Palliative Treatment	100%		100%	
Space Maintainers	Not Covered		Not Covered	
Basic				
Fillings	80% after deductible	80% after deductible	50%	50%
Surgical/Non-Surgical Periodontics	50% - Surg Perio after deductible 80% - Non-Surg after deductible	50% - Surg Perio after deductible 80% - Non-Surg after deductible		
Endodontics	80% after deductible	80% after deductible		
Simple Extractions				
Complex Oral Surgery				
General Anesthesia				
Denture Repairs/Adj/Relines/Rebases				
Major				
Inlays, Onlays, Crowns	50% after deductible	50% after deductible	50%	50%
Prosthetics				
Medically Necessary Orthodontics*	Not Covered	50%	Not Covered	

Certified Dental Plans meet the Healthcare Reform guidelines for pediatric dental coverage.
** Does not apply to the deductible.*

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