Subscriber Agreement

Blue Cross Dental Direct
Direct Plus Dental

BLUECROSS DENTAL

Blue Cross Blue Shield of Rhode Island

An Independent Licensee of the Blue Cross and Blue Shield Association

Nondiscrimination and Language Assistance

Blue Cross & Blue Shield of Rhode Island (BCBSRI) complies with applicable Federal civil rights laws and does not discriminate or treat people differently on the basis of race, color, national origin, age, disability, or sex.

BCBSRI provides free aids and services to people with disabilities and to people whose primary language is not English when such services are necessary to communicate effectively with us.

If you need these services, contact us at 800-639-2227.

If you believe that BCBSRI has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Director of Grievance and Appeals Department, Blue Cross & Blue Shield of Rhode Island, 500 Exchange Street, Providence RI 02903, or by calling 401-459-5000 or 800-639-2227 (TTY/TDD: 888-252-5051. TTY/TDD for Medicare plans: 401-831-2202 or 877-232-8432). You can file a grievance in person, by phone or by mail, fax, or electronically through our member portal. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

تاموللعمالو ةدعاسملا ىلع لوصحلا يف قحلا كيدلف Blue Cross & Blue Shield of Rhode Island صوصخب ةلئسأ هدعاست صخش ىدل وأ كيدل ناك إن 1-800-639-2227 بـ لصتا مجرتم عم ثدحتلل ةفلكتلا ةياً نود من كتغلبل ةيروريضلا

ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ ម្ននសំណួរអ្ំពី Blue Cross & Blue Shield of Rhode Island ឬ, អ្នកម្ននសិេធិេេួលជំនួយនិងព័ែ៌ម្ន ឬេៅកនុងភាសេ អរស់អ្នក ឬេេយមិនអ្ស់ឬ្ចក់ ។ បេ្ើមបីនិយាយជាមួយអ្នកេកប្រ សូម 1-800-639-2227។

如果您，或是您正在協助的對象，有關於[插入 項目的名稱 Blue Cross & Blue Shield of Rhode Island 方面的問題，您 有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-800-639-2227。

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross & Blue Shield of Rhode Island, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-800-639-2227.

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Blue Cross & Blue Shield of Rhode Island, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-800-639-2227.

Ọ bụrụ gị, ma o bụ onye I na eyere-aka, nwere ajụjụ gbasara Blue Cross & Blue Shield of Rhode Island, I nwere ohere iwenta nye maka na ọmụma na asụsụ gị na akwu gị ụgwọ. I chọrọ I kwụrụ onye-ntapịa okwu, kpọ 1-800-639-2227.

Se tu o qualcuno che stai aiutando avete domande su Blue Cross & Blue Shield of Rhode Island, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-800-639-2227.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이Blue Cross & Blue Shield of Rhode Island 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는1-800-639-2227로 전화하십시오.

I bale we, tole mut u ye hola, a gwee mbarga inyu Blue Cross & Blue Shield of Rhode Island, U gwee Kunde I kosna mahola ni biniiguene I hop wong nni nsaa wogui wo. I Nyu ipot ni mut a nla koblene we hop, sebel 1-800-639-2227.

ຖ້ າທ່ ານ, ຫຼື ຄ ນ ່ທທ່ ານກ ່ າວ ງຊ ່ ວຍເຫຼ ື ອ, ມ ່ ຄ າຖ າມກ ່ ຽວກ ັ ບ Blue Cross & Blue Shield of Rhode Island, ທ ່ ານມ ີ ສ ິ ດ ່ ທ ຈ ະ ໄ ດ ້ ຮ ັ ບ ກ ານຊ ່ ວ ຍ ເ ຫ ຼ ື ອ ຂ ແ ລ ະ ່ ຂ ໍ ້ ມ ູ ນ ຂ ່ າ ວ ສ ານ ່ ທ ເ ປ ັ ນ ພ າ ສ າ ຂ ອ ງ ທ ່ ານ ່ ່ ບ ມ ຄ ່ າ ໃ ຊ ້ จ ่ า ย. ภ า น ใ อ ้ ฉ ิ ม ภ ั บ ภ า ย พ า ส า, ใ ห ้ โ ท ห า 1-800-639-2227.

Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Blue Cross & Blue Shield of Rhode Island, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-800-639-2227.

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Blue Cross & Blue Shield of Rhode Island, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-800-639-2227.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross & Blue Shield of Rhode Island, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-639-2227.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross & Blue Shield of Rhode Island, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-639-2227.

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross & Blue Shield of Rhode Island, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-800-639-2227.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross & Blue Shield of Rhode Island, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-800-639-2227.

Bí ìwọ, tàbí ẹnikẹni tí o n ranlọwọ, bá ní ibeere nípa Blue Cross & Blue Shield of Rhode Island, o ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ongbufọ kan sọrọ, pè sórí 1-800-639-2227

This notice is being provided to you in compliance with federal law.

BLUE CROSS & BLUE SHIELD OF RHODE ISLAND
DENTAL *SUBSCRIBER AGREEMENT*

WELCOME

Welcome to Blue Cross & Blue Cross Blue Shield of Rhode Island (BCBSRI). We are pleased you have chosen us. We look forward to working with you and your family to meet your health care needs. Please carefully read the information provided in this *Subscriber Agreement* (the "*agreement*"). This is the *agreement* used by us to administer benefits and process *claims*.

If you have any questions about this *agreement*, providers, or benefits please contact our Customer Service Department before you obtain services. You can contact us at:

- Blue Cross & Blue Shield of Rhode Island
  500 Exchange Street
  Providence, RI 02903; or
- 401-459-5000 or 1-800-639-2227; or
- **www.BCBSRI.com.** (use our secure message service located on this website)

Below is a legal notice, some helpful tips, and phone numbers about your *plan*.

NOTICE

This is a legal *agreement* between you and Blue Cross & Blue Shield of Rhode Island. Your identification (ID) card will identify you as a *member* when you receive the dental services covered under this *agreement*. By presenting your ID card to receive *covered dental care 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 and Blue Shield Association ("the Association"), an association of independent Blue Cross and Blue Shield *plans*, permitting us to use the Blue Cross and 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*.

Kim A. Keck
President and Chief Executive Officer

IMPORTANT CONTACT INFORMATION AND WEBSITES

Customer Service – **(401) 453-4700 or 1-800-831-2400** or **Voice TDD 711(**711 is a national relay service for the deaf and hearing impaired). Our normal business hours are Monday - Friday from 8:00 a.m. – 8:00 p.m. Please see Section 1.5 for more details.

Blue Stores/Walk-in Service Centers – visit our website for specific locations and business hours.

Our Website - www.BCBSRI.com.

***HealthSource RI* – 1-855-683-6759.**

HELPFUL TIPS

- Read all information provided, especially this *Subscriber Agreement*. Become familiar with services excluded from coverage (See Section 4.0 – Dental Services Not Covered Under This *Agreement*.)
- In Section 8 – Glossary, there is a list of definitions of words used throughout this *agreement*. It is very helpful to become familiar with these words and their definitions.
- Identification Cards (ID) are provided to all *members*. The ID card must be shown when obtaining dental services. Your ID card should be kept in a safe location, just like money, credit cards or other important documents. BCBSRI should be notified immediately if your ID card is lost or stolen.
- Our list of *network dentists* changes from time to time. You may want to call our Customer Service Department in advance to make sure that a *dentist* is a *network dentist*.
- You are encouraged to become involved in your dental treatment by asking *dentists* about all treatment plans available and their costs.

SUMMARY OF BENEFITS

This is a summary of your dental benefit coverage levels under this *agreement*. It includes information about *coinsurance* and *deductibles*. This summary is intended to give you a general understanding of the dental coverage available under this *agreement*. Please read Section 3.0 for the description of coverage, benefit limits, and additional information about each particular covered service. Section 4.0 will provide a list of general exclusions. Words or phrases used throughout this *agreement* that are in italics are defined in Section 8.0 - Glossary.

The level of coverage and benefit limits are based on the age of the enrolled *member*.

For *members* under the age of 19:
In accordance with PPACA, this *agreement* provides coverage for the *dentally necessary* and *medically necessary* services listed in the Summary of Benefits labeled **"*MEMBERS UNDER AGE 19*".** The coverage for dental care services rendered to an enrolled child will end for the child on the first day of the month following their 19th birthday, unless otherwise specified in the Summary of Benefits.

If an enrolled *member* turns 19 years old during the *benefit year* and continues to be a *member* under this *agreement,* this *plan* will not cover services in excess of the *annual maximum benefit* or *benefit limits* listed for "*MEMBERS AGE 19 YEARS AND OLDER*". Services previously provided, during the *benefit year*, are counted in determining whether the *annual maximum benefit* or *benefit limits* have been met.

For *members* age 19 and older:
Please refer to the services listed in the Summary of Benefits labeled **"*MEMBERS AGE 19 YEARS AND OLDER".*** If a *covered dental care service* is rendered more than our contractually specified treatment time or age limitations, which are based on our dental policies and related guidelines, it is not covered.

IMPORTANT NOTE: All of our payments at the benefit levels noted below are based upon a fee schedule called our *allowance*. If you receive *covered dental services* from a *network dentist*, the *dentist* has agreed to accept our *allowance* as payment in full for *covered dental services*, excluding your *coinsurance.* If you receive *covered dental services* from a *non-network dentist*, you will be responsible for the *dentist's charge*. You will then be reimbursed based on the lesser of the *dentist's charge* or our *allowance* less any *coinsurance.* In addition, reimbursement for *covered dental services,* whether rendered by a *network* or *non-network dentist*, is always subject to your *annual maximum benefit.*

Members age 19 years and older must complete required *waiting periods* before benefits become available. If you end this *agreement* and re-enroll later, new *waiting periods* must pass before benefits become available again. See Section 3.0, Section 2.4, the definition of *waiting period* in Section 8.0 – Glossary and the Summary of Dental Benefits for details.

Annual Maximum Benefits/Maximum Out-of-Pocket Expense/Deductibles

Benefit Description	***Network Providers*** **You Pay**	***Non-network Providers*** **You Pay**
Deductible **– Per Individual** In the summary of Dental Benefits provided below, services subject to the *deductible* are indicated with "after *deductible*". *Deductible* applies to both *network* and *non-network providers* combined.		
Under age 19:	$25	
Age 19 and older:	Not Applicable	
Annual Maximum Benefit		
The maximum amount we pay for *covered dental services* per *member* per *benefit year*.		
Under age 19:	Unlimited	$1,500
Age 19 and older:	$1,500	$1,500
The *annual maximum benefit* applies to both *network and non-network* services combined.		
Maximum Out-of-Pocket Expense The *coinsurance* amounts apply to the *maximum out-of-pocket expense*. The *annual maximum out-of-pocket expense* applies to *network* services only.		
Individual *Plan*:		
Under age 19:	$350	Not Applicable
Age 19 and older:	Not Applicable	Not Applicable
Family *Plan*:		
Under age 19:	$700	Not Applicable
Age 19 and older:	Not Applicable	Not Applicable

Covered *Benefits*	***Network Providers*** **You Pay**	***Non-network Providers*** **You Pay**
See Section 3.0 – *Covered Health Care Services* for additional *benefit limits* and coverage information.		
Dental Care - Pediatric		
Dental Care Services: See Covered Dental Services section for *benefit limits* and details.		
Oral evaluations:		
Under age 19	0%	0%
Age 19 and older	0%	0%
X-rays:		
Under age 19	0%	0%
Age 19 and older	0%	0%
Cleanings (prophylaxis):		
Under age 19	0%	0%
Age 19 and older	0%	0%
Fluoride treatments:		
Under age 19	0%	0%
Age 19 and older	Not Covered	Not Covered
Sealants:		
Under age 19	0%	0%
Age 19 and older	Not Covered	Not Covered
Space maintainers:		
Under age 19	0%	0%
Age 19 and older	Not Covered	Not Covered
Palliative treatment:		
Under age 19	20%	20%
Age 19 and older	0%	0%
Fillings:		
Under age 19	50% - After *deductible*	50% - After *deductible*
Age 19 and older	20%	20%
Simple extractions:		
Under age 19	50% - After *deductible*	50% - After *deductible*
Age 19 and older	20%	20%
Denture repairs and relines/rebasing:		
Under age 19	50% - After *deductible*	50% - After *deductible*
Age 19 and older	50% - After 6 month waiting period	50% - After 6 month waiting period
Crowns & onlays:		
Under age 19	50% - After *deductible*	50% - After *deductible*
Age 19 and older	50% - After 12 month waiting period	50% - After 12 month waiting period
Therapeutic Pulpotomies:		
Under age 19	50% - After *deductible*	50% - After *deductible*
Age 19 and older	50% - After 12 month waiting period	50% - After 12 month waiting period
Root canal therapy:		
Under age 19	50% - After *deductible*	50% - After *deductible*
Age 19 and older	50% - After 12 month waiting period	50% - After 12 month waiting period
Non-surgical periodontal services:		
Under age 19	50% - After *deductible*	50% - After *deductible*
Age 19 and older	50% - After 12 month waiting period	50% - After 12 month waiting period
Surgical periodontal services:		
Under age 19	50% - After *deductible*	50% - After *deductible*
Age 19 and older	50% - After 12 month waiting period	50% - After 12 month waiting period
Periodontal maintenance:		
Under age 19	50% - After *deductible*	50% - After *deductible*
Age 19 and older	50% - After 12 month waiting period	50% - After 12 month waiting period

Covered *Benefits*	***Network Providers*** **You Pay**	***Non-network Providers*** **You Pay**
See Section 3.0 – *Covered Health Care Services* for additional *benefit limits* and coverage information.		
Fixed bridges and dentures:		
Under age 19	50% - After *deductible*	50% - After *deductible*
Age 19 and older	50% - After 12 month waiting period	50% - After 12 month waiting period
Single tooth implant:		
Under age 19	50% - After *deductible*	50% - After *deductible*
Age 19 and older	50% - After 12 month waiting period	50% - After 12 month waiting period
Oral surgery services:		
Under age 19	50% - After *deductible*	50% - After *deductible*
Age 19 and older	50% - After 12 month waiting period	50% - After 12 month waiting period
General anesthesia or IV sedation – dental office:		
Under age 19	50% - After *deductible*	50% - After *deductible*
Age 19 and older	50% - After 12 month waiting period	50% - After 12 month waiting period
Biopsies:		
Under age 19	50% - After *deductible*	50% - After *deductible*
Age 19 and older	50% - After 12 month waiting period	50% - After 12 month waiting period
Occlusal (night) guards:		
Under age 19	50%	50%
Age 19 and older	50%	50%
Medically necessary orthodontic services (braces):		
Under age 19	50% - After *deductible*	50% - After *deductible*
Age 19 and older	Not Covered	Not Covered

Blue Cross & Blue Shield of Rhode Island
Blue Cross Dental Direct
Subscriber Agreement

TABLE OF CONTENTS

1.0 INTRODUCTION

1.1 *Agreement* and Its Interpretation

Our entire contract with you consists of this *agreement* and your application, which is made a part of this *agreement*. In the absence of fraud, all your statements in the application are representations and not warranties. We will make a determination regarding your eligibility for benefits. We will construe the provisions of this *agreement* subject to your right to appeal or to take legal action as described in Section 7.0.

If this *agreement* changes, we will issue an amendment or new *agreement* signed by an officer of Blue Cross & Blue Shield of Rhode Island. 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 and federal law as amended from time to time.

1.2 How to Find What You Need to Know in this *Agreement*

The Summary of Benefits at the front of this *agreement* will show you:

- what dental care services are covered under this *agreement*;
- any benefit limits, *coinsurance* and deductibles you must pay; and
- services for which *predetermination* is recommended or required.

The Table of Contents will help you find the order of the sections, as they appear in the *agreement*:

- Section 1.0 - important introductory information;
- Section 2.0 - information about eligibility;
- Section 3.0 - covered health care services;
- Section 4.0 - health care services which are not covered under this *agreement*;
- Section 5.0 - how we pay for your covered health care services;
- Section 6.0 - how we coordinate benefits when you are covered by more than one *plan*;
- Section 7.0 - how to file a *claim* and how to appeal a *claim*; and
- Section 8.0 - words with special meaning.

1.3 Words With Special Meaning

Some words and phrases used in this *agreement* are in italics. This means that the words or phrases have a special meaning as they relate to your dental coverage. Section 8.0 – Glossary defines many of these words.

The sections below also define certain words and phrases:

- Section 3.0 - Covered Dental Services;
- Section 6.0 - How We Coordinate Your Benefits When You Are Covered By More Than One *Plan*;
- Section 7.0 - How To File And Appeal A *Claim*; and
- Section 7.7 - Our Right of Subrogation and Reimbursement.

1.4 You and Blue Cross & Blue Shield of Rhode Island

We, Blue Cross & Blue Shield of Rhode Island, agree to provide coverage for *dentally necessary covered dental care services* listed in this *agreement*. We only cover a service in this *agreement* if it is *dentally necessary*. We review *dental necessity* per our dental policies and related guidelines. The term *dentally necessary* is defined in Section 8.0 - Glossary. It does not include all dentally appropriate services.

This *agreement* does not apply pre-existing condition exclusions.

This *agreement* provides coverage for dental services that we have reviewed and determined are eligible for coverage based on our dental policies and related guidelines. Dental services, which we have not reviewed, are not covered under this *agreement*. Dental services, which we have reviewed and determined are not eligible for coverage, 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 services covered under this *agreement* along with their related exclusions. Section 4.0 lists general exclusions.

Genetic Information
This *agreement* does not limit your coverage based on genetic information.

We will not:
- adjust premiums based on genetic information;
- request or require an individual or family members of an individual to have a genetic test; or
- collect genetic information from an individual or family members of an individual before or in connection with enrollment under this *agreement* or at any time for underwriting purposes.

1.5 Customer Service/General Information

If you have questions about your benefits under this *agreement*, call the Blue Cross & Blue Shield of Rhode Island (BCBSRI) Customer Service Department at (401) 453-4700 or 1-800-831-2400 or Voice TDD 711. Our normal business hours are Monday - Friday from 8:00 a.m. – 8:00 p.m. If you call after normal business hours, our answering service will take your call. A BCBSRI Customer Service Representative will return your call on the next business day. When you call, please have your *member* ID number ready.

Below are a few examples of when you should call our Customer Service Department:
- To learn if a *dentist* participates with Blue Cross Dental;
- To ask questions and get information about your coverage;
- To file a complaint;
- To find out how to file a written appeal or learn about the status of your appeal;
- To obtain *predetermination* guidelines for covered dental services provided by a *non-network dentist* or by a Dental Coast to Coast *Network Dentist*, you or your *dentist* can call (401) 453-4700 or 1-800-831-2400 prior to receiving care.

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.

You may also visit one of our Blue Stores/walk-in services centers. See our website for specific locations.

1.6 Premiums and Grace Period

Premiums

We will send you a monthly bill. Premium due date is the first day of each month that this *agreement* is in effect. (Premium due date example: coverage effective July 1 through July 31, the premium due date is July 1.)

Grace Periods

A grace period is a time past the premium due date that we will accept the monthly premium payment. Under this *agreement*, the grace period ends on the last day of the calendar month in which the premium is due.(Example: for one calendar month grace period; coverage is effective July 1 through July 31, the last date we will accept the premium payment is July 31).

If you purchased coverage:

- directly from BCBSRI the grace period is one calendar month.
- through the *HealthSource RI*
  - and you do NOT receive advance payments of tax credits under your medical insurance policy, the grace period is one calendar month;
  - and you do receive advance payment of tax credits under your medical insurance policy; the grace period is three (3) calendar months after the premium due date. Please contact the Rhode Island Health Benefit Exchange for details.

If you do not make payment by the end of the grace period, this *agreement* will cancel as of the last day of the grace period. This is called termination for nonpayment of premiums. Any *claims* incurred after the end of the grace period will be your responsibility.

Reinstatement after Termination for Nonpayment of Premium

If you purchase coverage directly from BCBSRI and your coverage was terminated for nonpayment of premium, you will not be eligible to enroll in another BCBSRI direct pay *plan* at any time unless you pay any required premiums, including any overdue premiums and any premiums currently billed.

1.7 Our Right to Receive and Release Information About You

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

- adjudicating dental insurance *claims*;
- administration of *claim* payments;
- dental operations;
- case management and *utilization review*; and
- coordination of dental benefits.

Our release of information about you is regulated by law. 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 Health Insurance Portability and Accountability Act Final Privacy Regulations, 45 C.F.R. §§ 160.101 et seq., the Gramm-Leach-Bliley Financial Modernization Act, 15 U.S.C. §§ 6801-6908, and Regulation 100 adopted by the Rhode Island Office of the Health Insurance Commissioner (OHIC).

1.8 Our Right to Conduct *Utilization Review*

To be sure a *member* receives appropriate benefits; we reserve the right to conduct *utilization review*. We also reserve the right to contract with an organization to do *utilization review* on our behalf. If another company does *utilization review* on our behalf, the company will act as an independent contractor. The company is not a partner, agent, or employee of Blue Cross & Blue Shield of Rhode Island.

This *agreement* provides coverage only for *dentally necessary* care. The determination, by an entity conducting *utilization review*, whether a service is *dentally necessary* is solely for the purpose of *claims* payment and the administration of your dental benefit *plan*. It is not a professional dental judgment.

Although we may conduct *utilization review*, Blue Cross & Blue Shield of Rhode Island does not act as a *dentist*. We do not furnish dental care. We do not make dental judgments. You are not prohibited from having a treatment for which reimbursement has been denied. Nothing here will change or affect your relationship with your *dentist(s)*.

1.9 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 not obligated to provide you with a *dentist*. Also, we are not liable for anything your *dentist* does or does not do. We are not a dental provider. We do not practice dentistry, furnish dental care, or make dental judgments.

We review *claims* for payment to determine if the *claims*:

- constitute *dentally necessary* services for the purpose of benefit payment; and
- constitute *medically necessary* services for the purpose of benefit payment for orthodontic services; and
- are covered dental services under this *agreement*.

The determination by us of whether a service is *dentally necessary* or *medically necessary* is solely for the purpose of *claims* payment and the administration of dental benefits under this *agreement*. It is not an exercise of professional dental judgment.

1.10 Your Responsibility To Pay Your *Dentist*

Covered dental services may be subject to benefit limits, *deductibles* (if any) and *coinsurance*. It is your responsibility and obligation under this *agreement* to pay *network dentists* the *deductible* (if any) and *coinsurance* that may apply to covered dental services.

Your *dentist* may require payment at the time of service or may bill you after the service. If you do not pay your *dentist*, he or she may decline to provide current or future services or may pursue payment from you. Your *dentist* may, for example, begin collection proceedings against you. For more information, see Section 5.0 - How Your Covered Dental Services Are Paid.

2.0 ELIGIBILITY

You may purchase this *agreement* directly from us or from *HealthSource RI*.

If you purchased this *agreement* from us, this section of the *agreement* describes:

- who is eligible for coverage;
- when coverage begins;
- how to add or remove family members;
- when coverage ends; and
- continuation of coverage.

If purchased from *HealthSource RI*, eligibility determinations will be made by the *HealthSource RI*. Please contact the *HealthSource RI* at 1-855-683-6759 for questions about your eligibility.

2.1 Who is an *Eligible Person*

You: You are eligible to apply for coverage under this *agreement* if:

- you reside in Rhode Island; and
- you are not enrolled in coverage under Medicare which includes dental coverage.

Your Spouse: Your spouse is eligible to enroll for coverage under this *agreement* if you have selected family coverage. Only one of the following individuals may be enrolled at a given time:

- Your legal spouse, according to the laws of the state in which you were married, when your marriage was formed by obtaining a marriage license, having a marriage ceremony, and registering the marriage with the appropriate state or local official.
- Your common law spouse, according to the law of the state in which your marriage was formed. Your spouse by common law is eligible to enroll for coverage under this *agreement*. To be eligible, you and your common law spouse must complete and sign our Affidavit of Common Law Marriage and send us the required documentation. Please call us to obtain the Affidavit of Common Law Marriage.
- Your civil union partner, according to the law of the state in which you entered into a civil union. Civil Union partners may be enrolled only if civil unions are recognized by the state in which you reside.
- Domestic Partner:
    - your lawful registered domestic partner, according to the laws of the state in which you entered into a registered domestic partnership; or
    - your domestic partner, who is of the same sex, (regardless of whether you have obtained registration).
    - To be eligible, you and your domestic partner must complete and sign our Declaration of Domestic Partnership and we must receive the required documentation. Please call our Customer Service Department to obtain the Declaration of Domestic Partnership form.
- Former Spouse: In the event of a divorce, your former spouse will continue to be eligible for coverage provided that your divorce decree requires you to maintain continuing 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 date provided by the judgment for divorce; or
    - the date your former spouse has comparable coverage available through his or her own employment.

Your Children: Each of your and your spouse's children is eligible for coverage until the first day of the month following their 26th birthday. For purposes of determining eligibility under this *agreement*, the term child means:

- Natural Children;
- Step-children;
- Legally Adopted Children: In accordance with Rhode Island General Law § 27-20-14, 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 live in your home are eligible to enroll for coverage under this *agreement*.

We may request more information from you to confirm your child's eligibility.

Disabled Dependents

In accordance with Rhode Island General Law § 27-20-45, when your unmarried child who is enrolled for coverage under this *agreement* reaches the maximum dependent age limit age of twenty-six (26) and is no longer considered eligible for coverage, he or she continues to be an *eligible person* under this *agreement* if he or she is a disabled dependent.

If you have an unmarried child of any age who is medically certified as disabled and is chiefly dependent on you for support and care because of mental impairment or physical disability, which can be expected to result in death or can be expected to last for a continuous period of not less than twelve months, that child is an eligible disabled dependent under this *agreement*. If you have a child whom you believe satisfies these conditions, you must call us to obtain the form necessary to verify the child's disabled status and show proof of the disability. This form must be filled out and submitted to us. Periodically thereafter, you may be asked to show proof that this disabling condition still exists to maintain coverage for this child as a dependent.

2.2 When Your Coverage Begins

When You Can Enroll or Make Changes

You may enroll your eligible dependents during an Open Enrollment period. If your dependents do not enroll at this time, your dependents may only enroll if they enroll through a Special Enrollment Period.

This *agreement* goes into effect on the first day of the month for which we receive your completed application and you have paid the membership fees.

Under this *agreement*, the renewal date is January 1. This *agreement* will automatically renew on the renewal date as long as your membership fees are paid. The only exception would be if one of the events from Section 2.4 - When Your Coverage Ends applies.

Open Enrollment Period

An Open Enrollment Period will be held each year. You and/or your eligible dependents may enroll at this time by completing an application. Each year, the Annual Open Enrollment Period is determined by the federal government and the State of Rhode Island. Please contact Customer Service to obtain specific dates.

Special Enrollment Period

After your initial effective date, you may enroll your eligible dependents for coverage through a Special Enrollment Period by completing an application within sixty (60) days following the Special Enrollment event. You and/or your eligible dependents will qualify for a Special Enrollment Period as follows:

- If you get married, coverage begins the first day of the month following your marriage;
- If you have a child born to the family, coverage begins on the date of the child's birth;
- If you have a child placed for adoption with your family, coverage begins on the date the child is placed for adoption with your family.

In addition, if you lose your health insurance coverage, you may enroll or add your eligible dependents for coverage through a Special Enrollment Period by completing an application within sixty (60) days following the Special Enrollment event. Coverage will begin on the first day of the month following the date you lost coverage.. You and/or your eligible dependents will qualify for a Special Enrollment Period as follows:

- The *eligible person* seeking coverage had other coverage at the time that he or she was first eligible for coverage under this *agreement* and the coverage on the other *plan* is terminated as a result of loss of eligibility for coverage because of the following:
    - legal separation or divorce,
    - death of the covered individual,
    - termination of employment or reduction in the number of hours of employment,
    - the covered individual's becoming entitled to Medicare,
    - loss of dependent child status under the *plan*,
    - employer contributions to such coverage is being terminated,
    - *COBRA* benefits are exhausted,
    - your employer is undergoing Chapter 11 proceedings.

With a change in eligibility for Medicaid or a Children's Health Insurance Program CHIP, you must make written application within sixty (60) days following your change in eligibility. Coverage will begin on the first day of the month following the event. Or, if the event occurs on the first day of a month, coverage will begin under this *agreement* as of the first day of that month. You and/or your eligible dependents will qualify for a Special Enrollment Period as follows:

- you and/or your eligible dependent are terminated from Medicaid or CHIP coverage due to a loss of eligibility; or
- you and/or your eligible dependent become eligible for premium assistance, under your employer/agent's coverage, through Medicaid or CHIP.

In addition, you may also be eligible for the following Special Enrollment periods if you apply within sixty (60) days following the Special Enrollment event:

- If you or your dependent lose minimum essential coverage, coverage begins the first day of the following month;
- If you adequately demonstrate to us that another health *plan* substantially violated a material provision of its contract with you coverage begins based on the circumstances, either on the date of the Special Enrollment event, or:
- If the first of the following month you make a permanent move into the *service area* your enrollment or non-enrollment in a qualified health *plan* (QHP) is unintentional, inadvertent, or erroneous and is the result of error, misrepresentation, or inaction by us, *HealthSource*

RI, or the U.S. Department of Health and Human Services (HHS) coverage begins, based on the circumstances, either on the date of the Special Enrollment event, or:

- the first of the following month, if your application is received between 1st and 15th day of the month;
- the first of the second following month, if your application is received between the 16th and last day of the month.

If you purchased this *plan* through *HealthSource RI*, you may also be eligible for the following additional special enrollment periods. Please contact the *HealthSource RI* at 1-855-683-6759 for questions about these special enrollment periods and your eligibility within sixty (60) days following the Special Enrollment event.

- If you gain status as a citizen, a national, or a lawfully present individual:

- If your income situation has changed and you are determined to be newly eligible for the premium tax credit or the cost sharing reductions subsidy:

- If you are an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, you may enroll or change from one coverage to another one time per month:

- If you demonstrate to the *HealthSource RI*, in accordance with guidelines issued by Health and Human Services, that you meet other exceptional circumstances.

2.3 How to Add or Remove Coverage for Family Members

You must tell us if you want to add family members. See Section 2.2 above.

You must send notification to us if you want to take family members off your coverage. We will remove family members effective the first day of the month following the month in which we get notification from you.

We must get the notice to remove your family members at least fourteen (14) working days before the requested date of removal. If we do not receive your notice within this fourteen (14) working day period, you must pay 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*

Coverage under this *agreement* is guaranteed renewable. It can be canceled for the following reasons.

This *agreement* will end automatically:

- on the date membership fees due are not paid (see Section 1.5 -Premium and Grace Period);
- the first day of the month following that month in which you cease to be an *eligible person*;
- the first day of the month your dependent no longer qualifies as an eligible dependent;
- the first day of the month following that month in which you are no longer a Rhode Island resident;
- if we cease to offer this type of coverage;

- the date fraud is identified. Fraud includes, but is not limited to, intentional misuse of your identification card (ID card) and intentional misrepresentation of a material fact made by you, or on your behalf, that affects your coverage. Fraud may result in retroactive termination. You will be responsible for all costs incurred by Blue Cross & Blue Shield of Rhode Island due to the fraud. Blue Cross & Blue Shield of Rhode Island may decline reinstatement under your *Plans* for Individuals & Families coverage. We may decline enrollment in any other coverages we offer that may become available in the future, as well.

If you purchase coverage from the *HealthSource RI* and the Qualified Health *Plan* is terminated or decertified, coverage under this *agreement* will end.

Retroactive Cancellations
Rescind/Rescission means a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation is not a rescission if it:

- only has a prospective effect (as described above); or
- applies retroactively to the extent that such cancellation is due to the failure to timely pay premiums.

We may rescind your coverage if you or your dependents commit fraud. Fraud includes, but is not limited to, intentional misuse of your identification card (ID card) or intentional misrepresentation of material fact. Any benefit paid in the past will be voided. You will be responsible to reimburse us for all costs and *claims* paid by us. We must provide you a written notice of a rescission at least 30 days in advance. This notice will provide you the opportunity to appeal this decision. Please see Section 7.0 – How to File and Appeal a *Claim*.

Except for non-payment, we will not contest this policy after it has been in force for a period of two years from the later of the *agreement* effective date or latest reinstatement date.

When You End This *Agreement*
You may end this *agreement* by telling us in writing that you want to end coverage. We must get your notice to end this *agreement* at least fourteen (14) days before the requested date of cancellation. If we do not receive your notice within this fourteen (14) day period, you must pay another month's membership fees. Requests for retroactive cancellations will NOT be allowed.

If you change from one coverage to another coverage during an Open Enrollment or a Special Enrollment Period, your coverage under the original *agreement* will end.

If you purchased coverage from *HealthSource RI*, you may end this *agreement* by notifying HSRI in accordance with HSRI's policy. Please contact HSRI for details. If you purchased coverage from us, you may end this *agreement* by telling us in writing that you want to end coverage. We must get your notice to end this *agreement* at least fourteen (14) days before the requested date of cancellation. If we do not receive your notice within this fourteen (14) day period, you must pay another month's premium. Requests for retroactive cancellations will NOT be allowed.

For *Members* Age 19 Years and Older
If your coverage is terminated under this *agreement*, you may only re-apply if six (6) months from the cancellation date has passed. 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 you re-enroll your coverage at a later date, **new** *waiting periods* will apply before certain benefits become available again. See Summary of Benefits for details.

3.0 COVERED DENTAL CARE SERVICES

We cover the following services when rendered by a *dentist*.

All covered dental services are subject to the provisions below. See the Summary of Benefits to determine level of coverage and the amount you pay.

If a service or category of service is not specifically listed as covered, it is not covered under this *agreement*. Only services that we have reviewed and determined are eligible for coverage under this *agreement* are covered. All other services are not covered. See The Summary of Benefits to determine if a service or category of service is covered.

This *agreement* covers *multi-stage procedures* which have a *start date* before the effective date of this *agreement* if:

- the *multi-stage procedures* have a *completion date* after the effective date of this *agreement*; and
- the *multi-stage procedures* are covered dental services under this *agreement*.

Subject to any *plan year* or other maximums, we will pay up to our *allowance* less any benefits paid or payable under any previous *plan* for *multi-stage procedures*.

Pediatric Dental Care Services

In accordance with PPACA, this *agreement* provides coverage for the *dentally necessary* services listed in the Summary of Benefits for an enrolled child under the age of nineteen (19), when rendered by a *network dentist* or *non-network dentist*. The coverage for dental care services rendered to an enrolled child will end for the child on the first day of the month following their 19th birthday, unless otherwise specified in the Summary of Benefits. If a *covered dental care service* is rendered more than our contractually specified treatment time or age limitations, which are based on our dental policies and related guidelines, it is not covered.

3.1 DIAGNOSTIC & PREVENTIVE SERVICES

3.1.1 Oral Evaluations (Examinations)

We cover an initial oral examination, a periodic oral examination, or an emergency oral examination, (which includes diagnosis and charting), when performed by a general *dentist* (which includes pedodontists and prosthodontists), as indicated below:

- two examinations per *plan year* for *members* under age 19;
- one examination per *plan year* for *members* age 19 and older.

3.1.2 X-rays

We cover x-rays as indicated below:

- two (2) sets of bitewing x-rays per *plan year* for *members* under age 19;
- one (1) set of bitewing x-rays per *plan year* for *members* age 19 and older;
- four (4) single x-rays per *plan year*;
- one (1) full mouth set of intraoral (including bitewings) or panorex x-rays in a sixty (60) month period.

3.1.3 Cleanings

We cover:

- three (3) cleanings per *plan year* for *members* under age 19;
- two (2) cleanings per *plan year* for *members* age 19 and older.

3.1.4 Fluoride

We cover two (2) fluoride treatments per *plan year* for *members* under age 19.

3.1.5 Sealants

We cover one (1) sealant in a thirty six (36) month period on permanent molars for *members* under age 19.

3.1.6 Space maintainers

We cover space maintainers for one tooth per sixty (60) month period. Space maintainers are covered for premature loss of primary molars and permanent first molars, or when the primary molars and permanent first molars have not or will not develop.

3.2 BASIC DENTAL SERVICES

Waiting Periods For *Members* Age 19 Years and Older

Waiting periods may apply for certain benefits, please see the Summary of Benefits to determine which benefits require a waiting period. We will NOT cover services when a *start date* occurs during the *waiting period* in which benefits are not available.

3.2.1 Minor Treatment For Acute Dental Pain (Palliative)

We cover two (2) visits per *plan year* for treatment to relieve acute dental pain when definitive treatment to relieve the pain, (such as but not limited to, crown preparation, permanent fillings, and extractions), is not provided on the same day by the same *dentist*.

3.2.2 Fillings

We cover amalgam fillings (silver fillings) and composite fillings (white fillings). Composite fillings (white fillings) are only covered when used for your anterior (front) teeth. If composites (white fillings) are used as a filling material on posterior (back) teeth, you are responsible to pay for the difference between our *allowance* for the amalgam filling (silver filling) and the *dentist's charge*. Other restorative services include recementing of crowns or onlays.

3.2.3 Simple Extractions

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

3.2.4 Denture or Partial Repairs

We cover services to repair full or partial broken dentures once per thirty-six (36) month period per upper and lower dentures. Relining or rebasing of full or partial dentures by a lab is limited to once every thirty-six (36) month period.

3.3 MAJOR DENTAL SERVICES

Waiting Periods For *Members* Age 19 Years and Older

Waiting periods may apply for certain benefits, please see the Summary of Benefits to determine which benefits require a waiting period. We will NOT cover services when a *start date* occurs during the *waiting period* in which benefits are not available.

3.3.1 Crowns and Onlays

We cover single tooth crowns and onlays to restore natural teeth. Crowns and onlays that are not part of a bridge are covered. Replacements will be covered once in a sixty (60) month period, only if the existing crown or onlay is not serviceable and cannot be repaired.

Predetermination is recommended for this service. See Section 8.0 for the definition of *predetermination*.

3.3.2 Therapeutic Pulpotomies and Root Canal Therapy

We cover therapeutic pulpotomy for primary teeth.

We cover root canal therapy for all permanent teeth, excluding final restoration. *Predetermination* is recommended for this service. See the definition of *predetermination* in Section 8.0.

3.3.3 Non-Surgical Periodontics

We cover periodontal maintenance following documented periodontal surgery up to two (2) times per *plan year* if at least three (3) months have passed since the completion of active periodontal surgery.

We cover periodontal scaling and root planing once (1) per thirty-six (36) month period, per quadrant.

Predetermination is recommended for this service. See the definition of *predetermination* in Section 8.0.

3.3.4 Surgical Periodontics

We cover surgical periodontal services and procedures for the treatment of tissues supporting the teeth.

Most surgical periodontal services and procedures are limited to one per site/quadrant per thirty-six (36) month period.

Predetermination is recommended for this service. See Section 8.0 for the definition of *predetermination*.

3.3.5 Prosthodontics (Bridges, Dentures and Implants)

We cover services for fixed bridges and full or partial dentures. Replacements will be covered once in a sixty (60) month period only if the existing fixed bridge, full denture, or partial denture is not serviceable and it cannot be repaired.

We cover crowns over implants as a prosthodontic service. We cover a single tooth implant as a prosthodontic service, if placed as an alternative treatment to a conventional 3-unit

bridge and replaces only one missing tooth when there is *sound natural teeth* on either side.

Predetermination is recommended for this service. See Section 8.0 for the definition of *predetermination*.

3.3.6 Biopsies

We cover biopsies and examinations of hard or soft oral tissue.

3.3.7 Oral Surgery

We cover surgical extractions and other oral surgical procedures which are *dentally necessary* and meet our dental policies and related guidelines, only if the oral surgery is not a covered service under your medical insurance *plan*. General anesthesia is covered only when rendered in conjunction with a covered oral surgical procedure.

3.3.8 Occlusal (Night) Guards

We cover occlusal (night) guards once in a twelve (12) month period for members under the age of nineteen (19). Occlusal (night) guards are a removable dental appliance designed to minimize the effects of clenching and/or grinding on your teeth.

We cover occlusal (night) guard adjustments once in a twenty-four (24) month period for members under the age of nineteen (19).

Occlusal guards are not covered when used:

- to treat temporomandibular joint dysfunction, sleep apnea, or snoring; and
- as an athletic mouth guard or orthodontic retainer.

3.4 Orthodontics

We cover *medically necessary* orthodontics and related services for *members* under the age of 19.

Predetermination is recommended for this service. See Section 8.0 -definition of *predetermination*.

4.0 DENTAL SERVICES NOT COVERED UNDER THIS *AGREEMENT*

4.1 Services Not *Dentally Necessary*

This *agreement* does NOT cover services to identify or treat your dental or oral health conditions that are NOT *dentally necessary* in accordance with our dental policies and related guidelines (See Section 8.0 – Glossary). We will use any reasonable means to make a determination about the *dental necessity* of your care. We may examine dental records. We review *dental necessity* in accordance with our dental policies and related guidelines. You have the right to appeal our determination or to take legal action as described in Section 7.0.

We may deny payments if a *dentist* does not supply dental records needed to determine *dental necessity*. We also may deny or reduce payment if the records sent to us do not provide adequate justification for performing the service.

This *agreement* does NOT cover orthodontic services that are NOT *medically necessary* in accordance with our dental policies and related guidelines (See Section 8.0 – Glossary).

4.2 Services Not Listed in Section 3.0

This *agreement* only covers services listed under Section 3.0 - Covered Dental Services. Any service that is not specifically listed in Section 3.0- Covered Dental Services is NOT covered. See the Summary of Benefits for the age limits applicable to Covered Dental Services.

4.3 Services Covered by the Government

This *agreement* does NOT cover:

- dental expenses for any condition, illness or disease which should be covered by the United States government or any of its agencies, Medicare, any state or municipal government or any of its agencies (except emergency care when there is a legal responsibility to provide it);
- services for military-related conditions;
- services required as a result of war, declared or undeclared, or any military action which takes place after your coverage becomes effective.

4.4 Services and Supplies Mandated by Laws in Other States

Any *charges* for services and supplies which are required under the laws of a state other than the Rhode Island law and which are not provided under this *agreement* are NOT covered.

4.5 Services Provided By College/School Facilities

This *agreement* does NOT cover dental services received in a facility mainly meant to care for students, faculty, or employees of a college or other institution of learning.

4.6 Services Performed by People/Facilities Not Legally Qualified or Licensed

This *agreement* does NOT cover dental services performed in a facility or by a *dentist* or other person that is not legally qualified or licensed according to relevant sections of Rhode Island law or other governing bodies or who does not meet our credentialing requirements.

4.7 Services Performed by Excluded Providers

This *agreement* does NOT cover dental services performed by a *dentist* who has been excluded or debarred from participation in Federal programs such as Medicare and Medicaid. To determine whether a *dentist* has been excluded from a Federal program, visit the U.S.

Department of Human Services Office of Inspector General website (https://exclusions.oig.hhs.gov/) or the Excluded Parties List System website maintained by the U.S. General Services Administration (https://www.sam.gov/).

4.8 Services Not Performed Within Indicated Time Limitations

Dental services performed that do not comply with the timeframes and limitations as set forth in this *agreement* and in our dental policies and related guidelines are NOT covered.

4.9 Anesthesia

This *agreement* does NOT cover:

- general anesthesia and intravenous sedation unless rendered in conjunction with covered oral surgical procedures; and
- the services of an anesthesiologist.

4.10 Benefits Available from Other Sources

This *agreement* does NOT cover:

- the portion of costs for dental services you receive when there is no *charge* to you or would have been no *charge* to you absent this *agreement*;
- dental services when you can recover all or a portion of the cost of such services through a federal, state, county, or municipal law or through legal action. This is true even if you choose not to assert your rights under these laws or if you fail to assert your rights under these laws; or
- services received from a dental department maintained or on behalf of an employer, mutual benefit association, labor union, trustee, or similar group or person.

4.11 *Charges* for Administrative Services

This *agreement* does NOT cover:

- *charges* for missed appointments;
- *charges* for completion of *claim* forms; or
- other administrative *charges*; or
- additional fees, sometimes referred to as access fees, associated with concierge, boutique, or retainer practices.

4.12 Christian Scientist Practitioners

This *agreement* does NOT cover the services of Christian Scientist Practitioners.

4.13 Clerical Errors

If a clerical error or other mistake occurs, that error shall not deprive you of coverage under this *agreement*. A clerical error also does not create a right to benefits.

4.14 Consultations -Telephone

This *agreement* does NOT cover telephone consultations.

4.15 Cosmetic Services

This *agreement* does NOT cover cosmetic procedures.
Cosmetic procedures are performed:

- to refine or reshape dental structures that are not functionally impaired;
- to change or improve appearance or improve self-esteem; or

- for other psychological, psychiatric or emotional reasons.

4.16 Deductibles and *Coinsurance*

This *agreement* does NOT cover deductibles or *coinsurance*, if any.

4.17 Implants

This *agreement* does NOT cover:

- dental implants;
- implant support prosthesis; or
- other implant related services, except for a single tooth implant, as described in the Summary of Benefits.

4.18 Employment–Related Injuries

This *agreement* does NOT cover dental services when performed to treat work-related illnesses, conditions, or injuries whether or not you are covered by Workers' Compensation law, unless:

- you are self-employed, a sole stockholder of a corporation, or a member of a partnership;
- such work-related illnesses, conditions, or injuries were incurred in the course of your self-employment, sole stockholder, or partnership activities; AND
- you are not enrolled as an employee under a group dental *plan* sponsored by an employer other than the business or partnership described above.

4.19 Drugs/Medications

Injectable or prescription drugs are NOT covered.

4.20 Experimental/Investigational Services

This *agreement* does NOT cover experimental or investigational procedures or services. Experimental or investigational procedures or services are not included in our dental policies and related guidelines. Experimental or investigational means any dental procedure that has progressed to limited human application, but has not been recognized as clinically proven and effective.

4.21 New Dental Services

This *agreement* does NOT cover any new dental procedures or services that are not included in our dental policies and related guidelines.

4.22 Replacement Services

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

4.23 Research Studies

This *agreement* does NOT cover research studies.

4.24 Services Performed By Hospital Staff Employees

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

4.25 Services Completed Prior To The Effective Date

Services completed prior to the effective date of this *agreement* are NOT covered.

4.26 Services Provided By Relatives or Members of Your Household

This *agreement* does NOT cover *charges* for any services provided by a person who is a member of your household or the cost of any care provided by one of your relatives (by blood, marriage, or adoption).

4.27 Specialty Oral Examinations

We will NOT cover oral examinations (limited in scope) when performed by a *dentist* who limits his or 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.

4.28 Temporomandibular Joint Syndrome (TMJ)

This *agreement* does NOT cover:

- services for or related to the treatment of Temporomandibular Joint Dysfunction (TMJ) ; and
- appliances or restorations necessary to increase vertical dimensions or to restore the occlusion.

4.29 Travel Expenses

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

5.0 HOW YOUR COVERED DENTAL SERVICES ARE PAID

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.

Our *allowance* is the maximum amount to be paid for a covered dental service. We will not be responsible for more than the *allowance* even if more than one *dentist* renders a covered dental service.

You must file all *claims* within one *calendar year* of the date you receive a covered dental service. *Member* submitted *claims* that arrive after this deadline are invalid unless:

- it was not reasonably possible for you to file your *claim* prior to the filing deadline; AND
- you file your *claim* as soon as possible but no later than ninety (90) calendar days after the filing deadline elapses (unless you are legally incapable).

Our payments to you or the *dentist* fulfill our responsibility under this *agreement*. In accordance with Rhode Island General Law § 27-20-49, benefits may be assigned and with your written consent our payments can be made to a *non-network dentist*. Your benefits, however, 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 year of providing a covered dental 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:

- patient's name;
- your *member* identification number;
- the name, address, and telephone number of the *dentist* who performed the service;
- date and description of the service; AND
- *charge* for that service.

Please mail dental *claims* to:

Blue Cross & Blue Shield of Rhode Island
Dental *Claims* Administer
P.O. Box 69427
Harrisburg, PA 17106-9427

5.1 How *Network Dentists* Are Paid

We pay *network dentists* directly for covered dental services. You are responsible for the *coinsurance or deductibles* (if any), if any, which may apply to a covered dental service. The copayments and deductibles you are responsible for are determined at the date of service and will not be retroactively adjusted for payments we make to providers under provider incentive, risk-sharing, care coordination, value-based or similar programs. In addition, reimbursement for covered dental services is always subject to your *annual maximum benefit*. *Network dentists* agree not to bill, *charge*, collect a deposit from, or in any way, seek reimbursement from you for a covered dental service, except for the *coinsurance* and *deductible* (if any) which may apply to a covered dental service. It is your obligation to pay a *network dentist* your *coinsurance* and *deductible* (if any). If you do not pay the *network dentist*, the *dentist* may decline to provide current or future services or may pursue payment from you. See Section 1.9

– Your Responsibility to Pay Your *Dentists* for more information.

5.2 How *Non-Network Dentists* Are Paid

You are responsible for paying all *charges* from a *non-network dentist*. We reimburse you up to the *allowance*, less any *coinsurance* and/or *deductible* (if any) which may apply to a covered dental service or procedure. The copayments and deductible (if any) you are responsible for are determined at the date of service and will not be retroactively adjusted for payments we make to providers under provider incentive, risk-sharing, care coordination, value-based or similar programs. In addition, reimbursement for covered dental services is always subject to your *annual maximum benefit*. We reimburse you for *non-network dentist* services according to the same guidelines we use to pay *network dentists*.

In accordance with Rhode Island General Law §27-20-49, benefits may be assigned and with your written consent, payments may be made to a *non-network dentist*.

Our reimbursement for *non-network dentist* services in our *service area* will never be more than the amount we pay for *network dentist* services.

Our reimbursement for dental services provided by *non-network dentists* outside our *service area* will be based on our *allowance* for *non-network dentists* outside our *service area*. If an *allowance* for a specific dental service cannot be determined by reference to a fee schedule, reimbursement will be based upon a calculation that reasonably represents the amount paid to *network dentists*.

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 Rhode Island Office of the Health Insurance Commissioner (OHIC) in Regulation 48 and the National Association of Insurance Commissioners (NAIC). From time to time these rules may change before we issue a revised *subscriber agreement*. We use the COB regulations in effect at the time of coordination to determine benefits available to you under this *agreement*.

If this provision applies, the order of benefit determination rules as stated in this section will determine whether we pay benefits before or after the benefits of another *plan*.

Note: All services must be *dentally necessary* to be covered (Orthodontic services must be *medically necessary*). It does not matter if this *plan* is the primary or secondary *plan*. Covered dental services paid by other *plans* will be taken into consideration when determining any duration or visit limits. When this *plan* is secondary, covered dental services that in total are more than the duration or visit limits on this *plan*, will not be covered unless *dentally necessary*.

6.1 Definitions

The following definitions apply to Section 6:

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

- covered at least in part under one or more *plans* covering the person for whom the *claim* is made; AND
- 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 dental 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 dental care coverage must be determined without taking the existence of any other *plan* into consideration.

SECONDARY *PLAN* means a *plan* which 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* that has the benefit. The total payments you receive will never be more than the total cost for 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 *plan* covers you first:

- whether you are the main *subscriber* or a dependent;
- if married, whether you or your spouse was born earlier in the year;
- the length of time each spouse has been covered;
- if a parental custody or divorce decree applies; or
- if Medicare is your other coverage. If so, then Medicare guidelines apply.

(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.

If, however, you are a Medicare beneficiary, Medicare will be the primary *plan*. Medicare will provide the benefits first.

If one of your dependents covered under this *agreement* is a student, and has additional coverage through a student *plan*, then the benefits from the student *plan* will be determined before the benefits under this *agreement*.

(2.) Dependent Child/Parents Not Separated or Divorced - If dependent children are covered under separate *plans* of more than one person (i.e. "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* which 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' birth dates, 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:

- first, the *plan* of the parent with custody of the child;
- then, the *plan* of the spouse of the parent with custody of the child; AND
- 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 benefits under that parent's *plan* has actual knowledge of those terms, the benefits of that *plan* are determined first and the 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 dental 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.) Active/Inactive Employee - If you are covered under another dental *plan* as an employee (not laid off or retired), your benefits and those of your dependents under that *plan* will be determined before benefits under this *plan*. The *plan* covering the active employee and dependents will be the primary *plan*. The *plan* covering that same employee as inactive (retired or laid off) will be the secondary *plan* for that employee and dependents.

(5.) *COBRA*/Rhode Island Extended Benefits(RIEB) – If this *plan* is provided to you under *COBRA* or RIEB, and you are covered under another *plan* as an employee, retiree, or dependent of an employee or retiree, the *plan* covering you as an employee, retiree or dependent of an employee or retiree will be primary and the *COBRA* or RIEB *plan* will be the secondary *plan*.

(6.) 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*. Then, the other insurer will cover any allowable benefits you use over that amount. It will never be more than the total amount of coverage that would have been provided if benefits were not coordinated.

Maximum benefits paid by primary insurer
\+ Any remaining allowable expense to be paid by secondary insurer

Total Benefits Payable

6.4 Our Right to Make Payments and Recover Overpayments

If payments which should have been made by us according to this provision have actually been made by another organization, we have the right 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 ADVERSE BENEFIT DETERMINATION AND APPEALS

7.1 Adverse Benefit Determinations

An **adverse benefit determination** is any of the following:

- Denial of a benefit (in whole or part),
- Reduction of a benefit,
- Termination of a benefit,
- Failure to provide or make a payment (in whole or in part) for a benefit, and
- Rescission of coverage, even if there is no adverse effect on any benefit.

An appeal of an adverse benefit determination can be made either as an administrative appeal or as a medical appeal, as defined further in this section.

Our Customer Service Department phone number is at (401) 453-4700 or 1-800-831-2400.

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:

- the services were excluded from coverage;
- we failed to make payment (in whole or part) for a service;
- we determined that you were not initially eligible for coverage ;
- we determined that you were not eligible for coverage (for example, a rescission of coverage occurred);
- you or you or your provider did not follow Blue Cross & Blue Shield of Rhode Island's requirements; or
- other limitation on an otherwise covered benefit.

How to File a Complaint or Administrative Appeal

If you are dissatisfied with any aspect of our operation, the quality of care you have received, or you have a request for us to reconsider a full or partial denial of benefits, please call our Customer Service Department. The Customer Service Representative will try to resolve your concern. If it is not resolved to your satisfaction, you may file a complaint or administrative appeal verbally with the Customer Service Representative. If you wish to file a complaint related to the quality of care you received, you must do so within sixty (60) days of the incident. If you wish to file an administrative appeal, you must do so within one hundred eighty (180) days of receiving a denial of benefits. You are not required to file a complaint before filing an administrative appeal.

You may also file a complaint or administrative appeal in writing. To do so, you must provide the following information:

- name, address, *member* ID number;
- summary of the issue,

- any previous contact with Blue Cross & Blue Shield of Rhode Island;
- a brief description of the relief or solution you are seeking;
- any more information such as referral forms, *claims* or any other documentation that you would like us to review;
- the date of incident or service; and
- your signature.

If someone is filing a complaint or administrative appeal on your behalf, you must send us a notice with your signature, authorizing the individual to represent you in this matter.

Please mail the complaint or administrative appeal to:

Blue Cross & Blue Shield of Rhode Island
Dental Appeals
P.O. Box 69420
Harrisburg, PA 17106-9420

The Blue Cross Dental Unit will conduct a thorough review of your complaint or administrative appeal and respond in the timeframes set forth below.

Complaint
We will respond to your complaint in writing within thirty (30) calendar days of the date we receive your complaint and all necessary documentation to conduct the review. The determination letter will provide you with the rationale for our response as well as information on the next steps available to you, if any, if you are not satisfied with the outcome of the complaint.

Administrative Appeal
We will respond to your administrative appeal in writing or by phone within sixty (60) calendar days of our receipt of your administrative appeal and all necessary documentation to conduct the review. The determination letter or phone call will provide you with information regarding our decision.

BCBSRI does not offer a Level 2 administrative appeal. You may notify the Office of The Health Insurance Commissioner's Consumer Resource Program, RIREACH at 1-855-747-3224 about your concerns. Please refer to the Legal Action section below for more information.

7.3 Dental Appeal Procedures

A **Dental 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 service does not meet our *dental necessity* guidelines or orthodontics services were not *medically necessary*.

If we deny payment for a service for dental reasons, you will receive the denial in writing. The written denial you receive will explain the reason for the denial and provide specific instructions for filing a dental appeal.
Your *dentist* may file a dental appeal on your behalf. Your *dentist* can contact the Provider Call Center to initiate the dental appeal or submit the appeal and all applicable clinical documentation to the address below.

To file a dental appeal verbally, you may call our Customer Service Department at (401) 453-4700 or 1-800-831-2400.

You may also file a dental appeal in writing. To do so, you must provide the following information:

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

If a dental appeal is being filed on your behalf, you must send us a notice with your signature, authorizing the individual to represent you in this matter.

Written dental appeals should be sent to:

Blue Cross & Blue Shield of Rhode Island
Dental Appeals
P.O. Box 69420
Harrisburg, PA 17106-9420

You are entitled to the following levels of review when seeking a dental appeal.

Level 1 Review
You may request a Level 1 review for a dental 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 our Customer Service Department, but we strongly suggest that you submit your request in writing to ensure your request is accurately reflected. At any time during the Level 1 Review (or Level 2 Review, see below), you may supply additional information by mailing it to the address listed above. You may request copies of information relevant to your appeal (free of charge) by contacting our Grievance and Appeal Unit.

You will receive written notification of the determination on a First Appeal review within fifteen (15) business days of receipt of the appeal request and all necessary documentation.

Level 2 Review
You may request a Level 2 review (preferably in writing) if our denial was upheld during the Level 1 review process. Your Level 2 review will be reviewed by a *dentist* in the same or similar specialty as your treating *dentist*. You must submit your request for a Level 2 review within one hundred and eighty (180) calendar days of the date of the Level 1 review 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 and all necessary documentation.

Note: You may ask for an expedited review if the circumstances are an emergency. A review is considered emergent or urgent if, in the opinion of a *dentist* with knowledge of your condition, applying time periods for making a non-urgent *claim* determination would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal. Due to the urgent nature of an expedited Dental Appeal, to request an expedited Dental Appeal you or your *dentist* must call Blue Cross Dental at (401) 453-4700 or 1-800-831-2400. An expedited determination will be made not later than seventy-two (72) hours from the receipt of the dental appeal. Services that have already been rendered (*retrospective review*) are not eligible for expedited (urgent) review.

Expedited (Urgent) Review
You may ask for an expedited (urgent) appeal if the circumstances are an emergency.

A review is considered emergent or urgent if, in the opinion of an individual applying the judgment of a prudent layperson possessing an average knowledge of health and medicine, applying time periods for making a non-urgent appeal determination could seriously jeopardize your life or your health or your ability to regain maximum function. Likewise, a review is considered emergent or urgent if, in the opinion of a physician with knowledge of your health condition, applying time periods for making a non-urgent *claim* determination would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

To request you or your *dentist* or provider must call the Grievance and Appeals Unit at (401) 459-5000 or 1-800-639-2227 or fax your request to (401) 459-5005.

An expedited appeal determination for services that have not yet been rendered (a pre-service review) will be made not later than seventy-two (72) hours or in less than seventy-two (72) hours (taking into consideration medical exigencies) from the receipt of the request.

Services that have already been rendered (*retrospective review*) are not eligible for expedited (urgent) review.

External Appeal
If you remain dissatisfied with our appeal determination, you may request an external review by an outside review agency for any *claim* amount. There is no minimum dollar amount that a *claim* must be in order to file an external appeal.

To request an external review you must submit your request in writing to us within four (4) months of your receipt of the determination. We will forward your request to the outside review agency within five (5) business days, or two (2) business days for an expedited external appeal.

We may charge you a filing fee up to $25.00 per external appeal, not to exceed $75.00 per *calendar year*. We will refund you if the denial is reversed and will waive the fee if it imposes an undue hardship on you.

For all non-emergency appeals, the outside review agency will notify you of its determination within ten (10) business days of the agency's receipt of the information.

For all urgent external appeals, the outside review agency will notify you of its determination within two (2) business days.

The determination by the outside review agency is binding upon us.

This External Appeal is voluntary. This means you may choose to participate in this level of appeal or you may file suit in an appropriate court of law (Please see Section 7.4 Legal Action, below).

7.4 Legal Action

If you are dissatisfied with the decision on your *claim*, and have complied with applicable state and federal law, you are entitled to seek 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 Legal Action), the *member* or *dentist* may not ask for an appeal at the same level again, unless additional information that could impact such decisions can be provided.

Under state law, you may not begin court proceedings prior to the expiration of 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 6.1).

7.5 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 about one of our employees. In order to start a grievance, please call our Customer Service Department at (401) 453-4700 or 1-800-831-2400. 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 do not apply to *dental necessity* determinations, complaints regarding payments, *claims* of dental malpractice or to allegations that we are liable for the professional negligence of any *dentist* or other health care provider furnishing services under this *agreement*.

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 the *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 conclude 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 Our Right of Subrogation and/or Reimbursement

Definitions

SUBROGATION means we can use your right to recover money from a third party that caused you to be hurt or sick. We may also recover from any insurance company (including uninsured and underinsured motorist clauses and no-fault insurance) or other party.

REIMBURSEMENT means our right to be paid back any payments, awards or settlements that you receive from a third party. We can collect up to the amount of any benefit or any payment we made.

Subrogation

We may recover money from a third party that causes you to be hurt or sick. If that party has insurance, we may recover money from the insurance company. Our recovery will be based on the benefit or payment we made under this *agreement*. For example, if you are hurt in a car accident and we pay for your hospital stay, we can collect the amount we paid for your hospital stay from the auto insurer. If you do not try to collect money from the third party who caused you to be hurt or sick, you agree that we can. We may do so on your behalf or in your name. Our right to be paid will take priority over any *claim* for money by a third party. This is true even if you have a *claim* for punitive or compensatory damages.

Reimbursement

If we give you benefits or make payment for services under this *agreement* and you get money from a third party for those services, you must pay us back. This is true even if you receive the money after a settlement or a judgment. For example, if your auto insurance pays for your emergency room visit after a car accident, you must reimburse us for any benefit payment that we made.

We can collect the money no matter where it is or how it is designated. You must pay us back even if you do not get back the total amount of your *claim* against the third party. We can collect the money you receive even if it is described as a payment for something other than health care expenses. We may offset future payments under this *agreement* until we have been paid an amount equal to what you were paid by a third party. If we must pay legal fees in order to recover money from you, we can recover these costs from you. Also, the amount that you must pay us cannot be reduced by any legal costs that you have.

If you receive money in a settlement or a judgment and do not agree with our right to reimbursement, you must keep an amount equal to our *claim* in a separate account until the dispute is resolved. If a court orders that money be paid to you or any third party before your lawsuit is resolved, you must tell us quickly so we can respond in court.

Member Cooperation

You must give us information and help us. This means you must complete and sign all necessary documents to help us get money back. You must tell us in a timely manner about the progress of your *claim* with a third party. This includes filing a *claim* or lawsuit, beginning settlement discussions, or agreeing to a settlement in principle, etc. It also means that you

must give us timely notice before you settle any *claim*. You must not do anything that might limit our rights under this Section. We may take any action necessary to protect our right of subrogation and reimbursement.

8.0 GLOSSARY

When a defined term is used in this *agreement*, it will be italicized.

AGREEMENT means this document. It is a legal contract between you and Blue Cross & Blue Shield of Rhode Island.

ALLOWANCE is the maximum amount to be paid for a covered dental service. Our *allowance* for a covered dental service may include payment for other related services. See Section 5.0 - How Your Covered Dental Services Are Paid.

When you receive covered dental services from a *network dentist*, the *dentist* has agreed to accept our *allowance* as payment in full. You will be responsible to pay your *coinsurance* and *deductibles* (if any).

When you receive covered dental services from a *non-network dentist*, you will be responsible for payment up the *dentist's charge*. Our reimbursement will be based on the lesser of either our *allowance*, the *non-network dentist's charge*, less any *coinsurance* and *deductibles* (if any).

The *allowance* for covered services you receive at a *non-network dentist* outside our *service area* is based on a schedule of fees for services provided in that geographic area. You are responsible to pay the *non-network dentist's* full *charge*. Any required *coinsurance* or deductibles will be applied to the *allowance* before we reimburse you.

If a covered dental service is rendered more than once during our contractually specified treatment time limitations, which are based on our dental policies and related guidelines, only one covered dental service will be reimbursed.

ANNUAL MAXIMUM BENEFIT means the total amount that we will pay toward covered dental services per *subscriber* per *plan year* under this *agreement*.

CALENDAR YEAR means a 12-month period beginning on January 1st and ending December 31st.

CHARGES means the amount billed by a *dentist* without the application of any discount or negotiated fee arrangement.

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

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

COINSURANCE means a percentage of our *allowance* that you must pay for certain covered dental services. See the Summary of Benefits for your *coinsurance* amount, if any.

COMPLETION DATE* OR *INSERTION DATE means the date we use to determine when a *multi-stage procedure* is complete.

COVERED DENTAL CARE SERVICES means any service, treatment, or procedure which we have determined is eligible for reimbursement under this *agreement*. Reimbursement for covered dental services is always subject to you *annual maximum benefit*.

DEDUCTIBLE means the amount that you must pay each *plan year* before we begin to pay for certain *covered dental care services.* The *deductible* amount applied to a *covered dental service* expense is based on the lower of our *allowance* or the *dentist's charge*. See the Summary of Benefits for your *deductible*, if any.

***DENTAL NECESSITY* (*DENTALLY NECESSARY*)** means that the dental services provided by a *dentist* to identify or treat your dental or oral health condition, upon review by Blue Cross & Blue Shield of Rhode Island, are:

- consistent with the symptoms and appropriate and effective for the diagnosis, treatment, or care of the oral condition, disease, or injury for which it is prescribed or performed;
- appropriate with regard to generally accepted standards of medical practice within the medical community, dental practice within the dental community, or scientific evidence;
- not primarily for the convenience of the *member*, the *member's* family or *dentist* of such *member*; AND
- the most appropriate in terms of type, amount, frequency, setting, duration, and level of service to the *member's* diagnosis or condition which can safely be provided to the *member*.

We will make a determination whether a dental service is *dentally necessary* based on our dental policies and related guidelines. You have the right to appeal our determination or to take legal action as described in Section 7.0.

We may review *dental necessity* on a case-by-case basis. WE DETERMINE *DENTAL NECESSITY* SOLELY FOR PURPOSES OF *CLAIMS* PAYMENT IN ACCORDANCE WITH OUR DENTAL POLICIES AND RELATED GUIDELINES UNDER THIS *AGREEMENT*.

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 dental services are rendered at the time and place that comparable laws are effective. The services must be performed within the scope of the individual's license.

ELIGIBLE PERSON is explained in Section 2.1. See Section 2.1 for a description of who is eligible to enroll as a dependent under this *agreement*.

HEALTHSOURCE RI means a Rhode Island governmental agency that makes Qualified Health *Plan* (QHPs) available to qualified *members*. It works as a marketplace to help residents identify health insurance options. To contact, please call 1-855-683-6759.

MAXIMUM OUT-OF-POCKET EXPENSE means the total amount of *coinsurance* that you must pay each *plan year* for certain *covered dental care services* provided by *network dentists*.

We will pay up to 100% of our *allowance* for the rest of the *plan year* once you have met the *maximum out-of-pocket expense*.

See the Summary of Benefits for your *maximum out-of-pocket expense*s.

MEDICALLY NECESSARY means the orthodontic services provided to treat your skeletal and/or occlusal discrepancy upon review by Blue Cross & Blue Shield of Rhode Island are:

- appropriate and effective for the diagnosis, treatment, or care of the condition for which it is prescribed or performed; and
- appropriate with regard to generally accepted standards of medical practice within the medical community, dental practice within the dental community, or scientific evidence;
- not primarily for the convenience of the *member*, the *member's* family or provider of such *member*; AND
- the most appropriate in terms of type, amount, frequency, setting, duration, supplies or level of service to the *member's* diagnosis or condition which can safely be provided to the *member*, i.e. no less expensive professionally acceptable alternative is available.

We will make a determination whether the orthodontic service is *medically necessary*. You have the right to appeal our determination or to take legal action as described in Section 7.0. We review *medical necessity* on a case-by-case basis.

THE FACT THAT YOUR *DENTIST* PERFORMED OR PRESCRIBED A PROCEDURE DOES NOT MEAN THAT IT IS *MEDICALLY NECESSARY*. We determine medical necessity solely for purposes of *claims* payment under this *agreement*.

MEMBER means a person enrolled in this *plan*, whether a *subscriber* or other *eligible person*.

MULTI-STAGE PROCEDURE means any procedure which may require more than one office visit to complete.

***NETWORK DENTIST* (*NETWORK*)** is a *dentist* that has entered into an agreement with us. *Network dentists* include any *dentist* who participates in the Dental Coast to Coast *Network*.

***NON-NETWORK DENTIST* (*NON-NETWORK*)** is a *dentist* that has not entered into an agreement with us.

PLAN means any dental service *plan* or dental 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 as well as:

- group insurance or group-type coverage, whether insured or self-insured, including group-type coverage through an HMO, other prepayment group practice or individual practice *plan*; AND
- coverage under a governmental *plan* or coverage required to be provided by law. This does not include a state *plan* under Medicaid (Title XIX, Grant to States for Medical Assistance Programs, of the U.S. Social Security Act as amended from time to time).

PLAN YEAR means a 12-month period beginning on January 1st and ending December 31st.

PREDETERMINATION is a procedure whereby your *dentist* sends to us your treatment plan before treatment is rendered. *Predeterminations* are an estimate, not a guarantee of payment. The *predetermination* estimates are based on your eligibility status and benefits at the time the request is processed. It is subject to change.

Obtaining *predetermination* is NOT a requirement in order for planned covered dental service to be covered.

However, if you decide to have the dental service when the *predetermination* is that the service is not covered, you will be responsible for the cost of the dental service. This is true whether you have the service rendered by a network or *non-network dentist*. You have the right to appeal or to take legal action as described in Section 7.0.

Network dentists may get *predetermination* for all covered dental services. This includes, but is not limited to, multiple restorations, periodontics (treatment of gums), prosthodontics (bridges and dentures) and orthodontics.

When your *dentist* is *non-network*, you or the *non-network dentist* may obtain a *predetermination*. You may inquire about *predeterminations* by calling us at (401) 453-4700 or 1-800-831-2400.

SERVICE AREA means the geographic area *members* may access a *dentist* with a direct contract with Blue Cross & Blue Shield of Rhode Island.

SOUND NATURAL TEETH means teeth that:

- are free of active or chronic clinical decay;
- have at least fifty percent (50%) bony support;
- are functional in the arch; and
- have not been excessively weakened by multiple dental procedures.

START DATE* OR *PREPARATION DATE means the date we use to determine when a *multi-stage procedure* begins.

SUBSCRIBER is the person who enrolls in this *plan* and signs the application on behalf of himself or herself and on behalf of the other individuals listed as eligible on the application.

UTILIZATION REVIEW means the prospective (prior to) or retrospective (after) review of any service to determine whether such service constitutes a *dentally necessary* service for purposes of benefit payment in accordance with our dental policies and related guidelines and is a covered dental service under this *agreement*.

Prospective Review is a review done prior to services being rendered.
Retrospective Review is a review done after services have been rendered.

WAITING PERIOD is the designated number of months during which *members* 19 years old or older must be enrolled in the *plan* before Major Restorative benefits, Oral Surgery benefits and certain Basic (non-preventative) benefits become available for coverage. If you cancel your coverage under this *agreement* and reinstate later, new *waiting periods* will apply before benefits become available again. See Section 3.0 and Summary of Benefits for details.

WE, US, and **OUR** means Blue Cross & Blue Shield of Rhode Island. We are located at 500 Exchange Street, Providence, Rhode Island, 02903. In this *agreement*, WE, US, or OUR will have the same meaning whether italicized or not.

YOU and **YOUR** means the enrolled *subscriber* or *member* to Blue Cross & Blue Shield of Rhode Island. In this *agreement*, YOU and YOUR will have the same meaning whether italicized or not.

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Plan = On/Off Exchange QDP DIR DEN Plus v1.17

Blue Cross Blue Shield of Rhode Island
www.BCBSRI.com
500 Exchange Street • Providence, RI 02903-2699