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

DENTAL BLUE®

BLUE CROSS and BLUE SHIELD OF MASSACHUSETTS, Inc.
May, 2006

Consumer Disclosure

Safe and Healthy Lives in Safe and Healthy Communities
Consumer Disclosure

CONSUMER'S RIGHT TO KNOW ABOUT HEALTH PLANS

THE HEALTH CARE ACCESSIBILITY AND QUALITY ASSURANCE ACT

WHY ARE YOU GETTING THIS INFORMATION?

- Knowing how Health Plans work helps you to be a better consumer.
- Meets State Law requiring Health Plans to disclose information.
- Provides information about your specific Health Plan.
- Informs you that a comprehensive list of all participating providers is available to you on the Health Plan Web Site (Hard copies available on request.)

Another document, the Consumer's Guide to Health Plans in Rhode Island, gives general information about health plans, including standard definitions of common terms, and is available upon request from Health Plan representatives. This document can also be found on the RI Department of Health Web Site, www.healthri.org.

This Consumer Disclosure has been reviewed and approved by the Rhode Island Department of Health in accordance with R23-17.13 (Rules and Regulations for Certifying Health Plans). Requests for more information about Health Plan certification or consumer rights may be addressed to:

Rhode Island Department of Health, Division of Health Services Regulation, 3 Capitol Hill, Providence, RI 02908-5097, Phone: 401 222-6015.

Q Who can I contact at the Health Plan for information?

Representatives of this Health Plan are available to help you get the information you need. You can contact a Health Plan representative at:

A

Blue Cross and Blue Shield of Massachusetts, Inc.
Member Services
P. O. Box 9134
North Quincy, MA 02171-9134
Toll free: 1-800-296-3917
TDD Number 800-522-1254
Fax: 617-246-6313
Web address: www.bcbsma.com

Para contactar a un representante que hable Espanol, llame a: Departamento de Servicios Para Miembros 1-800-367-7781
**Q** How does the health plan review and approve covered services?

A health plan may review covered services that are recommended by providers to decide if the services are medically necessary. If the plan decides the service is not medically necessary, it will not pay. You and your provider can appeal the Health Plan's decision. For more information about appeals see the Consumer's Guide to Health Plans in Rhode Island.

**A**

All dental care must be necessary and appropriate. As defined by your subscriber certificate:

- Your dental care must be consistent with the prevention and treatment of oral disease or with the diagnosis and treatment of teeth that are decayed or fractured, or where the supporting structure is weakened by disease (including periodontal, endodontic and related diseases).
- Your dental care must be furnished in accordance with standards of good dental practice.
- Your dental care must not be solely for your convenience or the convenience of your dentist.

Based on a review of dental records describing your condition and treatment, the Dental plan’s staff, including dental consultants, uses their professional judgment to determine available benefits for certain types of procedures, including but not limited to crown restorations, periodontal services, oral surgery and fixed bridgework. A dental consultant reviews the treatment plan objectively and determines whether the services are within the scope of benefits, and whether these services are necessary and appropriate for you.

Based on the Dental plan’s findings, the Dental plan may determine that a service is not necessary and appropriate for you, even if your dentist has recommended, approved, prescribed, ordered or furnished the service.

If the Dental plan decides the service is not medically necessary or appropriate according to the subscriber certificate, it will not pay. You and your dentist can appeal the Dental plan's decision.

**Q** What if I have an emergency?

An emergency is a problem that needs to be addressed by a provider "right-away" to prevent permanent damage or death. Here's what this Health Plan wants you to do when you have an emergency health care problem, at home or out of state.

**A**

Covered dental services are listed in your official plan document. This Dental plan covers emergency treatment by a dentist in their office to relieve acute dental pain or to control a dental condition that requires immediate care to prevent permanent harm to the member. These benefits are also available when furnished by a non-participating dentist when furnished in an emergency and a participating dentist is not reasonably available.

**Q** What if I refuse a referral to a participating provider (a doctor, a nurse, or other professional in your Health Plan's network) (not applicable to single service Health Plans)

When a specific covered service is recommended, Health Plans may send you to certain
participating providers. If you refuse the referral and get the service from another provider, the Health Plan must tell you what effect it will have on payment.

A
Not applicable to Dental plans. You may go directly to a participating provider without a referral.

Q Does the Health Plan require that I get a second opinion for any services? What if I want a second opinion?
In some cases the Health Plan may require a second opinion before it will pay for a covered service. Or you may just want a second opinion on a plan for diagnosis or treatment.

A
Second opinions are not required. If you choose one, the consultation is a covered benefit only when a dentist who is not providing the treatment is the consultant.

Q How does the Health Plan make sure that my personal health information is protected and kept confidential?
In general, personal health information must be kept confidential (private) by a Health Plan, its employees and agencies it contracts with. Here's how the Health Plan makes sure that personal health information is protected.

A
We only collect personal or medical information we need to carry out our business. We are required by law to protect the confidentiality of your personal and medical information. We will supply your information to you upon your request or to help you understand treatment options and other benefits available to you. We also may use and disclose your information without your written authorization for the following purposes and as otherwise permitted or required by law: Treatment, Payment, Health Care Operations, Legal Compliance, Research and Public Health, to an Account or Party It Designates (for administration of its health plan (For example, to a self-insured account for claim review and audits). Disclosure only to designated individuals, along with contract obligations, helps protect your information from unauthorized use. To carry out these purposes, we share information with entities that perform functions for us subject to contracts that limit use and disclosure for intended purposes. We use physical, electronic, and procedural safeguards to protect your privacy. Even when allowed, use and disclosure are limited to the minimum amount reasonably necessary for the intended task. Special protections apply to certain medical conditions. For example, with very few exceptions allowed by law, we will not release any information regarding HIV or AIDS to any party without your written permission. Also, we will not release mental health treatment records to you without first receiving written permission from your treating provider. For additional information, please call the Member Service toll free number on your ID card or visit our website at www.bluecrossma.com.
Q How am I protected from discrimination?
You have the right to be treated fairly and equally. Health Plans may not discriminate against you due to age, sex, religion, race or ethnic origin, disability, occupational status or any other characteristics protected by law.
A
You have a right to receive impartial treatment. You have the right to all medically indicated treatment that is a covered benefit and is determined by the Dental plan to be Medically Necessary and appropriate, regardless of your age, sex, religion, race or ethnic origin, disability, occupational status or any other characteristics protected by law.

Q If I refuse treatment, will it affect my future treatment?
If you refuse to be treated for any condition, your Health Plan must tell you what effect your decision will have on future coverage.
A
The Dental plan does not impose restrictions on the right to refuse treatment. You may refuse treatment at your discretion and it will not affect your access to that treatment in the future.

Q How does the health plan pay providers?
Your health plan must tell you about the kinds of financial arrangements it has with providers.
A
This Dental plan is not capitated and does not contain other risk sharing arrangements.

Q How is my health insurance renewed or canceled?
A
This Dental plan will be renewed on the employer’s anniversary date unless your employer chooses another plan. Your coverage may only be cancelled if your employer fails to pay premiums for your group, if you cease to be eligible for coverage under the Dental plan or if fraud is documented.

Q If I am covered by two or more health plans, what should I do?
If you or a family member is covered by two or more Health Plans, you may have to give information on your coverage to each Health Plan. This helps the Health Plans to arrange payments between the plans when you or a family member receives a service. Here's what this plan will ask you to tell them.
The Plan will coordinate payment of covered services with medical or other plans under which you are covered. The Plan will do this to make sure that the cost of your dental care services is not paid more than once.

You must include information on your enrollment forms about other dental plans under which you are covered. Once you are enrolled under this contract, you must notify the Plan if you add or change health plan coverage. Upon request, you must also supply the Plan if you add or change dental coverage. Upon request you must also supply the plan with information about other plans that may provide you with coverage for dental services.

Health Benefits Required Under Rhode Island Law as of September 2000:

Health Maintenance Organizations (HMOs) and health insurers in Rhode Island are required by State law to provide enrollees with coverage for certain kinds of health care services. These laws do not apply to Medicare, Medicaid, ERISA self-funded plans or supplemental (e.g. Medigap) or single disease (e.g. Cancer coverage) health insurance policies (check with your workplace benefits administrator. These mandated benefits (see summary list in Consumer’s Guide to Health Plans in RI) often apply only under certain circumstances, may be limited to participating providers, and are not always covered in full--other conditions and restrictions not mentioned here may apply. For more information about specific mandated benefits, contact your Health Plan representative or the Rhode Island Department of Business Regulation at 401 222-2223.

Covered Services at a Glance:

The information on the following pages shows you what services are covered under this Health Plan. This is only a summary. You may find complete information in the Official Plan Documents or contact the Health Plan Representative listed on the first page.

Single Service Health Plans (example: dental care, vision care) must provide you with standardized and easy-to-understand information about covered services -- including out-of-pocket costs, service limitations and other things you need to know. Single Service Health Plans can do this through general information materials or by using a special insert summary called "Covered Services at a Glance." For more complete information, read the Official Plan Documents or contact a Health Plan Representative. Using this information, you can compare:

- Health Plans
- Out-of-pocket costs
- Limits on services
### Covered Services at a Glance

<table>
<thead>
<tr>
<th>Type of Service (Not All Services are Listed)</th>
<th>Is Prior Authorization Required (Yes/No)</th>
<th>What Out-of-Pocket Expenses Will I Have to Pay?</th>
<th>What Other Limitations Apply?</th>
<th>If I Choose a Non-Participating Provider Will the Service be Covered?</th>
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<tr>
<td>An employer can select either Level 1 or 2 of Dental Blue and Dental Blue PPO and can choose a different coverage level for each benefit group. For example, an employer may choose to cover preventive services at 100 percent, basic services at 80 percent, and major services at 50 percent, but may not select orthodontic coverage. There is an annual benefit maximum per covered member and a separate lifetime maximum for orthodontics. An employer may also choose to include a deductible for services per individual, not exceeding a preset family deductible per calendar year. For specific information about your benefits, contact the Dentist’s Information Center at 1-800-882-1178, option 3. <strong>Dental Blue</strong>: Dental Blue is an indemnity-based dental plan. Dental Blue members can see any participating dentist for treatment. <strong>Dental Blue PPO</strong>: Dental Blue PPO is a managed care dental plan. Members can see an in-state non-par provider. The allowance will be based on the provider’s charge. The member will be responsible for the payment up to the provider’s charge.</td>
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| Call plan or check Official Plan Documents for details | No Prior Authorization is recommended for all dental services over $250.00 | Members are only liable for applicable deductibles and co-insurance up to their benefit maximums. Deductibles and co-insurance will vary on all Dental Blue Plan 1 and 2, Dental Blue PPO Plan 1 and 2, depending on the plan designs and coverage levels and benefit riders selected by the employer. For specific information about your benefits, contact the Dentist’s Information Center at 1-800-882-1178, option 3. | For a complete description of a members limitations and exclusions please reference your Dental Blue or Dental Blue PPO Subscriber Certificate. Or for specific information about your benefits, contact the Dentist’s Information Center at 1-800-882-1178, option 3. | Dental Blue: members cannot receive payment for services rendered by and in-state non-participating provider unless their employer has purchased the BCS life benefit to cover in state non-par providers. If the employer has purchased the BCS life benefit the allowance may be lower than the plans maximum allowable fee schedule. The member will be responsible for payment up to the provider’s charge. |
can receive dental services from an in-network dentist (Dental Blue PPO) at a higher level of reimbursement, or they can receive services from an out-of-network dentist (non-Dental Blue PPO) at a reduced level of reimbursement.

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<th>Preventive (Group 1)</th>
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<td><strong>Diagnostic</strong></td>
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<td>• One complete initial oral exam, including initial history and charting of the teeth and supporting structures</td>
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<td>• Single tooth radiographs</td>
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<td>• Bitewing radiographs</td>
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<td>• Full mouth radiographs, 7 or more films, or panoramic radiographs with bitewing radiographs</td>
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<td>• Study models and casts used in planning treatment once each 60 months</td>
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<tr>
<td>• Emergency exams when dentist does no perform another covered service during visit.</td>
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<td>• Periodic or routine oral exams once each six months</td>
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<tr>
<td><strong>Preventive</strong></td>
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<tr>
<td>• Routine cleaning, scaling, and polishing of the teeth once each six months</td>
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<td>• Fluoride treatment (members under age 19) once each six moths</td>
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<td>• Space maintainers needed due to premature tooth loss (members under age 19)</td>
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<tr>
<td>• Sealant applied to permanent molars and premolars (members under age 14) Benefits are provided for one application per pre-molar or molar surface each 48 moths</td>
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<th>Basic (Group 2)</th>
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<td><strong>Restorative</strong></td>
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balance between BCBSMA’s payment and the provider’s charges.
- Amalgam fillings
- Composite resin fillings on anterior teeth
- Sedative fillings
- Pin retention for fillings
- Stainless steel crowns on primary teeth and first permanent molars

**Oral Surgery**
- Tooth extractions
- Root removal
- Biopsies

**Periodontic**
- Periodontal scaling and root planing
- Periodontal surgery (curettage, osseous surgery)
- Periodontal maintenance following active* periodontal therapy

**Endodontics**
- Root canal therapy or retreatment root canal therapy on permanent teeth
- Therapeutic pulpotomy
- Endodontic surgery

**Prosthetic Maintenance**
- Repair of partial or complete dentures, crowns and bridges
- Repair or replacement of teeth on existing complete or partial denture
- Rebase or reline dentures
- Recementing or crowns, inlays, onlays, and fixed bridge work

**Other Services**
- Services to treat root sensitivity
- General anesthesia
- Emergency dental treatment

**Major (Group 3)**

**Prosthodontics**
- Complete or partial dentures
- Fixed bridges
- Replacement of dentures and bridges
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<td>bridge</td>
<td>complete or partial denture</td>
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<td><strong>Major Restorative</strong></td>
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<td>Complete orthodontic exam</td>
<td>Cephalometric radiograph</td>
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<td>active orthodontic treatment</td>
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