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

Blue Cross and Blue Shield of Massachusetts, Inc.
Dental Blue
March 2008

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:

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Blue Cross and Blue Shield of Massachusetts, Inc., Member Service, P. O. Box 9134, North Quincy, MA 02171-9134.
Toll Free: 800-296-3917; TDD Number: 800-522-1254; Fax: 617-246-6313
Web address: www.bluecrossma.com
Para contactor a un representante que hable Espanol, llame a:Departamiento de Services 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.

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All dental care must be necessary and appropriate as defined by the subscriber certificate and in accordance with standards of good dental practice. Based on a review of dental records describing your condition and treatment, the Dental plan's staff uses their professional judgment to determine available benefits for certain types of procedures. 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. 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.

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Covered dental services are listed in the applicable subscriber certificates and riders. 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, nurse, or other health 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.

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Referrals are not applicable to Dental plans.

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

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Second opinions are not required. If you choose one, the consultation is a covered service only when the dentist who renders the consultation does not also provide the treatment.

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.

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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 also may use and disclose your information without your written authorization only as permitted or required by law. Disclosure only to designated individuals helps protect your information from unauthorized use. We use physical, electronic, and procedural safeguards to protect your privacy. Special protections apply to certain medical conditions. 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.

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You have a right to receive impartial treatment. You have the right to all medically/dentally indicated treatment that is a covered service and is determined by the Dental plan to be 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.

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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.

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

Q **How is my health insurance coverage renewed or canceled?**

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This Dental plan will be renewed on the employer's renewal date unless your employer chooses another dental plan or cancels dental coverage. The applicable subscriber certificates and riders provide complete information about termination of coverage. For example, your coverage may 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 are covered by two or more Health Plans, you may have to give information on your coverage to each Health Plan. This helps the Health Plans to arrange payments between the plans when you or a family member receive a service. Here's what this plan will ask you to tell them.

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We will coordinate payment of covered services with hospital, medical, dental, health or other plans under which you are covered. When you enroll, you must notify us about other plans under which you are covered. After you are enrolled, you must notify us if you add or change health plan coverage. Upon request, you must supply us with information about other plans that may provide you with coverage for health care 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

Annual Deductible: Indiv-depends on plan type/Family-depends on plan type	**Max Lifetime Cap**: Indiv.-depends on plan type/Family-depends on plan type

Type of Service (Not All Services are Listed) Call plan or check Official Plan Documents for details	Is Prior Authorization Required (Yes/No)	What Out-of -Pocket Expenses Will I Have to Pay?	What Other Limitations Apply?	If I Choose a Non-Participating Provider Will the Service be Covered?
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 a your benefits, contact Member Service on the phone number listed on the front of your identification card. ***Dental Blue®.*** Dental Blue is an indemnity-based dental plan. Dental Blue members can see any participating dentist for treatment. ***Dental Blue® PPO.*** Dental Blue PPO is a managed care dental plan. Members can receive dental services from an in-	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 a your benefits, contact Member Service on the phone number listed on the front of your identification card.	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 a your benefits, contact Member Service on the phone number listed on the front of your identification card.	**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 non-par providers. If the employer has purchased the BCS life benefit the allowance will be reduced by 20% of the plans maximum allowable fee schedule. The member will be responsible for payment up to the provider's charge. **Dental Blue PPO:** 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

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.				balance between BCBSMA's payment and the provider's charges.
Preventive (Group 1)				
Diagnostic • Complete initial oral evaluation & charting of the teeth & supporting structures • Single tooth radiographs • Bitewing radiographs • Full mouth radiographs, 7 or more films, or panoramic radiographs with bitewing radiographs • Study models and casts • Evaluation–problem focused • Periodic or routine oral evaluation **Preventive** • Routine cleaning • Fluoride treatment • Space maintainers • Sealant applied to permanent molars and premolars				
Basic (Group 2)				
Restorative • 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 • Adding teeth to an existing bridge • Adding teeth to an existing complete or partial denture • Temporary partial dentures to replace any of the 6 upper or lower anterior teeth **Major Restorative** • Crowns; metallic, resin and porcelain onlays • Replacement of crowns and onlays				

• Post and core or crown build-up. • Single tooth dental implants.				
Orthodontic				
<u>Orthodontics</u> • Complete orthodontic exam • Cephalometric radiograph • Comprehensive or limited active orthodontic treatment including appliances				