

# **Subscriber Agreement**

## **Blue Cross Dental Direct PLUS Plan**



An Independent Licensee of the Blue Cross and Blue Shield Association

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

**WELCOME**

Welcome to Blue Cross & Blue Cross Blue Shield of Rhode Island (BCBSRI). 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*.



Peter Andruszkiewicz  
President and Chief Executive Officer

## 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.

## IMPORTANT TELEPHONE NUMBERS 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. - 4:30 p.m. Please see Section 1.5 for more details.

**Our Website - [www.BCBSRI.com](http://www.BCBSRI.com).**

**HealthSource RI – 1-855-683-6759.**

## DEPENDENT AGE LIMITS

<b>Dependent Age</b>	<b>See Section 2.1 – Who is Eligible for Coverage.</b>
<b>Dependent Children</b>	Children are covered until the first day of the month following their 26 <sup>th</sup> birthday.

## SUMMARY OF BENEFITS

This is a summary of your dental benefit coverage levels under this *agreement*. It includes information about *coinsurance*, *deductibles*, and visit limits. This summary is intended to give you a general understanding of the dental coverage available under this *agreement*. For more detailed information, please read Section 3.0 for the description of coverage for each particular covered service along with the related exclusions, and Section 4.0 for 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 columns of the Summary of Benefits labeled “**MEMBERS UNDER THE AGE OF 19**”.

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 19 YEARS OLD 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 columns of the Summary of Benefits labeled “**MEMBERS 19 YEARS OLD 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 19 years old and older must be enrolled in this plan for twelve (12) months before benefits for crowns, inlays, prosthodontic, and surgical periodontic services become available. If you end this agreement and re-enroll later, a new twelve (12)-month waiting period must pass before benefits for crowns, inlays, prosthodontic, and**

**surgical periodontic services become available. See Section 3.3.1, Section 3.3.4, Section 3.3.5, the information in Section 2.4, and the definition of *waiting period* in Section 8.0 – Glossary.**

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

Benefit Description	Benefit Description/Limit	<u>MEMBERS UNDER THE AGE OF 19</u>		<u>MEMBERS 19 YEARS OLD AND OLDER</u>	
		Network dentist	Non-network dentist	Network dentist	Non-network dentist
<b>Annual Maximum Benefit</b>	The maximum amount we pay for covered dental services per member per benefit year.	Unlimited	\$1,750	\$1,750  The <i>annual maximum benefit</i> applies to both <i>network and non-network</i> services combined. If an enrolled <i>member</i> turns 19 years old during the <i>benefit year</i> and continues to be a <i>member</i> under this <i>agreement</i> , this plan will not cover services in excess of the <i>annual maximum benefit</i> listed for “MEMBERS 19 YEARS OLD AND OLDER”. Services previously provided, during a <i>benefit year</i> , are counted in determining whether the <i>annual maximum benefit</i> has been met.	
<b>Maximum Out-of-Pocket Expense</b>	Individual	\$350	N/A	N/A	N/A
	Family - The <i>benefit year</i> family <i>maximum out-of-pocket expense</i> is met by adding the amount of covered dental care expenses applied to the <i>maximum out-of-pocket expense</i> for <i>members</i> under the age of 19; however no one (1) family <i>member</i> can contribute more than \$350 towards the <i>benefit year</i> family <i>maximum out-of-pocket expense</i> .  The <i>coinsurance</i> amounts apply to the <i>maximum out-of-pocket expense</i> .  The <i>annual maximum out-of-pocket expense</i> applies to <i>network</i> services only.	\$700	N/A	N/A	N/A

## Dental Benefits

Service Type, Dentist, or Place of Service	Benefit Limit	<u>MEMBERS UNDER THE AGE OF 19</u>		<u>MEMBERS 19 YEARS OLD AND OLDER</u>	
		Network <i>dentist</i>	Non-network <i>dentist</i>	Network <i>dentist</i>	Non-network <i>dentist</i>
	<p><b>NOTE:</b> If an enrolled <i>member</i> turns 19 years old during the <i>benefit year</i> and continues to be a <i>member</i> under this <i>agreement</i>, this plan will not cover services in excess of the <i>benefit limits</i> listed for “MEMBERS 19 YEARS OLD AND OLDER”. Services previously provided, during the <i>benefit year</i>, are counted in determining whether <i>benefit limits</i> have been met.</p>	For a covered dental care service you pay:	For a covered dental care service you pay the difference between the charge amount and the allowance plus:	For a covered dental care service you pay:	For a covered dental care service you pay the difference between the charge amount and the allowance plus:
<b>Diagnostic and Preventive Services</b>					
<ul style="list-style-type: none"> <li>Oral Evaluations</li> </ul>	One examination per <i>benefit year</i> . Exam includes: The initial examination or periodic examination, or emergency oral evaluation, when performed by a general dentist including diagnosis and charting per <i>benefit year</i> .	N/A	N/A	0%	0%
	Two examinations per <i>benefit year</i> . Exams include: The initial examination or periodic examination, or emergency oral evaluation, when performed by a general dentist including diagnosis and charting per <i>benefit year</i> .	0%	0%	N/A	N/A

Service Type, Dentist, or Place of Service	Benefit Limit	<b><u>MEMBERS UNDER THE AGE OF 19</u></b>		<b><u>MEMBERS 19 YEARS OLD AND OLDER</u></b>	
		<b>Network dentist</b>	<b>Non-network dentist</b>	<b>Network dentist</b>	<b>Non-network dentist</b>
	<b>NOTE:</b> If an enrolled <i>member</i> turns 19 years old during the <i>benefit year</i> and continues to be a <i>member</i> under this <i>agreement</i> , this plan will not cover services in excess of the <i>benefit limits</i> listed for “MEMBERS 19 YEARS OLD AND OLDER”. Services previously provided, during the <i>benefit year</i> , are counted in determining whether <i>benefit limits</i> have been met.	For a covered dental care service you pay:	For a covered dental care service you pay the difference between the charge amount and the allowance plus:	For a covered dental care service you pay:	For a covered dental care service you pay the difference between the charge amount and the allowance plus:
<ul style="list-style-type: none"> <li>X-rays</li> </ul>	Single x-rays limited to 4 per 6 month period.	0%	0%	0%	0%
	Bitewing limited to one (1) set per <i>benefit year</i> .	0%	0%	0%	0%
	Limited to one full mouth series (FMX) or panorex per 60-month period.	0%	0%	0%	0%
	X-rays other than those listed above.	50%	50%	20%	20%
<ul style="list-style-type: none"> <li>Cleanings (Prophylaxis)</li> </ul>	Two (2) cleanings per <i>benefit year</i> .	0%	0%	0%	0%
<ul style="list-style-type: none"> <li>Fluoride Treatments</li> </ul>	Two (2) fluoride treatment for <i>members</i> under 19 years old per <i>benefit year</i> .	0%	0%	Not Covered	Not Covered
<ul style="list-style-type: none"> <li>Sealants</li> </ul>	For permanent molars only. Limited to one per tooth in a 24-month period for <i>members</i> under 19 years old.	0%	0%	Not Covered	Not Covered
<ul style="list-style-type: none"> <li>Space Maintainers</li> </ul>		0%	0%	20%	20%
<b>Basic Dental Services</b>					
<ul style="list-style-type: none"> <li>Palliative Treatment</li> </ul>	Minor treatment to relieve sudden, intense pain.	50%	50%	20%	20%
<ul style="list-style-type: none"> <li>Fillings</li> </ul>	See Section for details.	50%	50%	20%	20%
<ul style="list-style-type: none"> <li>Simple Extractions</li> </ul>	Removal of erupted tooth (non-surgical).	50%	50%	20%	20%
<ul style="list-style-type: none"> <li>Denture</li> </ul>	Full or partial dentures.	50%	50%	20%	20%



Service Type, Dentist, or Place of Service	Benefit Limit	<b><u>MEMBERS UNDER THE AGE OF 19</u></b>		<b><u>MEMBERS 19 YEARS OLD AND OLDER</u></b>	
		<b>Network dentist</b>	<b>Non-network dentist</b>	<b>Network dentist</b>	<b>Non-network dentist</b>
	<b>NOTE:</b> If an enrolled <i>member</i> turns 19 years old during the <i>benefit year</i> and continues to be a <i>member</i> under this <i>agreement</i> , this plan will not cover services in excess of the <i>benefit limits</i> listed for “MEMBERS 19 YEARS OLD AND OLDER”. Services previously provided, during the <i>benefit year</i> , are counted in determining whether <i>benefit limits</i> have been met.	For a <i>covered dental care service</i> you pay:	For a <i>covered dental care service</i> you pay the difference between the charge amount and the <i>allowance</i> plus:	For a <i>covered dental care service</i> you pay:	For a <i>covered dental care service</i> you pay the difference between the charge amount and the <i>allowance</i> plus:
Repairs and Relines/ Rebasing	Relines/Rebasing limited to once in a 60-month period.				
<b>Major Dental Services</b>					
<ul style="list-style-type: none"> <li>• Crowns &amp; Onlays</li> </ul>	Replacement is limited to once in a 60 month period.  <i>Predetermination</i> is recommended.	50%	50%	50% (12 month <i>waiting period</i> applies)	50% (12 month <i>waiting period</i> applies)
<ul style="list-style-type: none"> <li>• Therapeutic Pulpotomies</li> </ul>	Limited to <i>members</i> under 14 years old.	50%	50%	Not Covered	Not Covered
<ul style="list-style-type: none"> <li>• Root Canal Therapy - Anterior(front) Teeth</li> </ul>		50%	50%	20%	20%
<ul style="list-style-type: none"> <li>• Root Canal Therapy - Posterior (back)Teeth</li> </ul>		50%	50%	20%	20%
<ul style="list-style-type: none"> <li>• Non-Surgical Periodontal Services</li> </ul>		50%	50%	20%	20%
<ul style="list-style-type: none"> <li>• Surgical Periodontal Services</li> </ul>	<i>Predetermination</i> is recommended.	50%	50%	50% (12 month <i>waiting period</i> applies)	50% (12 month <i>waiting period</i> applies)
<ul style="list-style-type: none"> <li>• Periodontal Maintenance</li> </ul>	Limited to two (2) services in a <i>benefit year</i> .	50%	50%	20%	20%

Service Type, Dentist, or Place of Service	Benefit Limit	<b><u>MEMBERS UNDER THE AGE OF 19</u></b>		<b><u>MEMBERS 19 YEARS OLD AND OLDER</u></b>	
		<b>Network dentist</b>	<b>Non-network dentist</b>	<b>Network dentist</b>	<b>Non-network dentist</b>
	<b>NOTE:</b> If an enrolled member turns 19 years old during the <i>benefit year</i> and continues to be a <i>member</i> under this <i>agreement</i> , this plan will not cover services in excess of the <i>benefit limits</i> listed for “MEMBERS 19 YEARS OLD AND OLDER”. Services previously provided, during the <i>benefit year</i> , are counted in determining whether <i>benefit limits</i> have been met.	For a covered dental care service you pay:	For a covered dental care service you pay the difference between the charge amount and the <i>allowance</i> plus:	For a covered dental care service you pay:	For a covered dental care service you pay the difference between the charge amount and the <i>allowance</i> plus:
<ul style="list-style-type: none"> <li>Fixed Bridges and Dentures</li> </ul>	<p>Coverage for replacements limited to one (per tooth/unit) in a 60-month period.</p> <p>Crowns over implants are considered a prosthodontic service.</p> <p><i>Predetermination</i> is recommended.</p>	50%	50%	50% (12 month <i>waiting period</i> applies)	50% (12 month <i>waiting period</i> applies)
<ul style="list-style-type: none"> <li>Single Tooth Implant</li> </ul>	<p>Coverage if placed as an alternative treatment to a conventional 3-unit bridge. Replacing only one missing tooth.</p> <p>Coverage for replacements limited to one (1) in a 60-month period.</p>	50%	50%	50% (12 month <i>waiting period</i> applies)	50% (12 month <i>waiting period</i> applies)
<b>Oral Surgery Services</b>	Limited to coverage when services are not covered under the member's medical insurance.				
<ul style="list-style-type: none"> <li>General Anesthesia or IV Sedation</li> </ul>	Covered as a separate benefit when performed in conjunction with a covered oral surgery procedure(s).	50%	50%	20%	20%
<ul style="list-style-type: none"> <li>Oral Surgery Services</li> </ul>		50%	50%	20%	20%

Service Type, Dentist, or Place of Service	Benefit Limit	<b><u>MEMBERS UNDER THE AGE OF 19</u></b>		<b><u>MEMBERS 19 YEARS OLD AND OLDER</u></b>	
		<b>Network dentist</b>	<b>Non-network dentist</b>	<b>Network dentist</b>	<b>Non-network dentist</b>
	<b>NOTE:</b> If an enrolled member turns 19 years old during the <i>benefit year</i> and continues to be a <i>member</i> under this <i>agreement</i> , this plan will not cover services in excess of the <i>benefit limits</i> listed for “MEMBERS 19 YEARS OLD AND OLDER”. Services previously provided, during the <i>benefit year</i> , are counted in determining whether <i>benefit limits</i> have been met.	For a covered dental care service you pay:	For a covered dental care service you pay the difference between the charge amount and the <i>allowance</i> plus:	For a covered dental care service you pay:	For a covered dental care service you pay the difference between the charge amount and the <i>allowance</i> plus:
• Biopsies	Limited to the biopsy and examination of oral tissue, soft or hard.	50%	50%	20%	20%
<b>Occlusal (Night) guards</b>	Limited to one (1) every five (5) years.	50%	50%	50%	50%
<b>Orthodontic Services (Braces)</b>	<i>Predetermination</i> is recommended. Only <i>medically necessary</i> braces are covered.	50%	50%	Not Covered	Not Covered

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

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## 1.0 INTRODUCTION

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### 1.1 Agreement and Its Interpretation

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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

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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

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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**

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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**

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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. - 4:30 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 *pre-determination* 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](http://www.bcbsri.com).

## **1.6 Premiums and Grace Period**

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### **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 *Rhode Island Health Benefit Exchange*
  - 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**

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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**

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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**

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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**

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*Covered dental services* may be subject to *benefit limits* and *coinsurance*. It is your responsibility and obligation under this *agreement* to pay *network dentists* the *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

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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

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**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 or Medicaid that 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 opposite sex spouse, according to the statutes 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 (generally, common law spouses are of the opposite-sex). Your spouse by common law of the opposite gender 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 necessary proof. Please call us to obtain the Affidavit of Common Law Marriage.
- Your same-sex 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 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 necessary 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:

- i. the date either you or your former spouse are remarried;
- ii. the date provided by the judgment for divorce; or
- iii. 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 as ordered by a Qualified Medical Child Support Order ("QMCSO") or until the first day of the month following their 26<sup>th</sup> 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 the *eligible person* under this *agreement* 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 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 as a dependent for this child.

## **2.2 When Your Coverage Begins**

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### **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 *calendar year* 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. Your enrollment date will be effective based on the receipt date of your application. The 2015 Annual Open Enrollment Period (AOEP) will be held between November 15, 2014 and February 15, 2015. Coverage will be effective as follows:

- apply between 11/15/14 -12/15/14, coverage will be effective 1/1/2015;
- apply between 12/16/14-1/15/15, coverage will be effective 2/1/2015; or
- apply between 1/15/15-2/15/15, coverage will be effective 3/1/2015.

### **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.

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 event. 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 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;
- you adequately demonstrate to us that we substantially violated a material provision of our *agreement* with you coverage begins:
  - 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
- you make a permanent move into the service area coverage begins:
  - 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.
- 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 of us, HealthSource RI, or the U.S. Department of Health and Human Services (HHS)
  - 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 purchased from 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, coverage begins:
  - 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 16<sup>th</sup> and last day of the month.
- 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
  - 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 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, coverage begins
  - 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 demonstrate to the HealthSource RI, in accordance with guidelines issued by Health and Human Services, that you meet other exceptional circumstances, coverage begins:
  - 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.

### **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 of 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;
- the date abuse or disregard for *provider* protocols and policies is identified by us. If after making a reasonable effort the *provider* is unable to establish or keep a satisfactory relationship with a *member*, coverage may end after thirty-one (31) days' written notice. Examples of unsatisfactory *provider* and patient relationships include:
  - abusive or disruptive behavior in a *provider*'s office;
  - repeated refusals by a *member* to accept procedures or treatment recommended by a *provider*; and

- impairing the ability of the *provider* to provide care.

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 coverage during an Open Enrollment or a Special Enrollment Period, your coverage under the original *agreement* will end.

If you purchase coverage from the HealthSource RI, you may end this *agreement* by telling the HealthSource RI, in writing that you want to end coverage. (See section 2.0)

### **For Members 19 Years and Older**

If your coverage is terminated under this *agreement*, you may only re-apply if twelve (12) 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, a **new twelve (12)-month waiting period** must pass before *benefits* become available for certain *covered dental services* as described in Sections 3.16 and 3.17.



### **3.0 COVERED DENTAL SERVICES**

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We cover the following services when rendered by a *dentist* (See Section 8.0 - Glossary for definition of *dentist*). **All covered dental services are subject to the provisions below.**

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 *calendar 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*.

### **3.1 DIAGNOSTIC & PREVENTIVE SERVICES**

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#### **3.1.1 Oral Evaluations**

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We cover oral evaluation and/or emergency oral evaluation. See the Summary of Benefits for benefit limits.

#### **3.1.2 X-rays**

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We cover one (1) set of bitewing x-rays per *benefit year*. Single x-rays coverage is limited to 4 single x-rays per six (6) month period. One (1) full mouth set of intraoral (including bitewings) or panorex x-rays is covered every sixty (60) months.

#### **3.1.3 Cleanings**

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We cover two (2) cleanings per *benefit year*.

#### **3.1.4 Fluoride**

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This *agreement* covers fluoride treatment for *members* under the age of 19. There is a limit of two (2) fluoride treatment in a *benefit year*.

#### **3.1.5 Sealants**

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Sealants are covered for *members* under the age of 19. Sealants are limited to one (1) sealant in a twenty-four (24) month period on permanent molars.

#### **3.1.6 Space maintainers**

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Space maintainers that are not made of cast precious metals are covered.

### **3.2 BASIC DENTAL SERVICES**

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#### **3.2.1 Minor Treatment For Acute Dental Pain**

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We cover minor treatment to reduce or relieve acute dental pain when necessary.

#### **3.2.2 Fillings**

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This *agreement* covers amalgam fillings (silver fillings). This *agreement* covers composite fillings (white fillings), for your anterior (front) teeth only. 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 Extractions**

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The simple extraction of an erupted tooth which does not require a surgical procedure will be covered.

### **3.2.4 Denture or Partial Repairs**

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Services to repair broken dentures or partials are covered. Relining or rebasing of full or partial dentures by a lab is limited to once every sixty-month (60) period.

## **3.3 MAJOR DENTAL SERVICES**

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### **3.3.1 Crowns and Onlays**

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This *agreement* covers 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 only if the existing crown or onlay is more than five (5) years old, is not serviceable, and cannot be repaired.

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

**Waiting Period:** Members 19 years old and older must be enrolled in the *plan* for twelve (12) months before benefits become available for crowns and onlays. If you cancel your coverage under this *agreement* and reinstate later, a new *twelve (12)-month waiting period* must pass before benefits become available for these services.

We will NOT cover crowns and onlays that have a *start date* during the *twelve (12)-month waiting period* that must pass before benefits become available for these services.

### **3.3.2 Root Canal Therapy**

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We cover root canal therapy for all permanent teeth, excluding final restoration.

We cover therapeutic pulpotomy for *subscribers* under the age of 14.

### **3.3.3 Non-Surgical Periodontics**

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*Pre-determination* is recommended for this service. See the definition of *pre-determination* in Section 8.0.

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

Periodontal scaling and root planing is covered up to one (1) time per twenty-four (24)-month period per quadrant.

### **3.3.4 Surgical Periodontics**

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This *agreement* covers services and surgical procedures for the treatment of tissues supporting the teeth.

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

**Waiting Period:** Members 19 years old and older must be enrolled in the *plan* for twelve (12) months before benefits become available for surgical periodontics. If you cancel your coverage under this *agreement* and reinstate later, a new *twelve (12)-month waiting period* must pass before benefits become available for these services.

We will NOT cover surgical periodontics that have a *start date* during the *twelve (12)-month waiting period* that must pass before benefits become available for these services.

### **3.3.5 Prosthodontics**

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Fixed bridges and partial or complete dentures are covered services for *members*. Replacements will be covered only if the existing fixed bridge, partial denture or complete denture meets the following criteria: it is more than five (5) years old, it is not serviceable, and it cannot be repaired.

This *agreement* covers crowns over implants as a prosthodontic service for *members*. This *agreement* covers a single tooth implant as a prosthodontic service for *members*.

**Waiting Period:** *Members* 19 years old and older must be enrolled in the *plan* for twelve (12) months before benefits become available for prosthodontic services. If you cancel your coverage under this *agreement* and reinstate later, a new *twelve (12)-month waiting period* must pass before benefits become available for these services.

We will NOT cover prosthodontic services that have a *start date* during the *twelve (12)-month waiting period* that must pass before benefits become available for these services.

### **3.3.6 Biopsies**

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Biopsies are limited to the biopsy and examination of oral tissue, hard or soft.

### **3.3.7 Oral Surgery**

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Surgical extractions and other oral surgical procedures which are *dentally necessary* and meet our dental policies and related guidelines are covered 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**

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This *agreement* provides coverage for occlusal (night) guards, a removable dental appliance designed to minimize the effects of clenching and/or grinding on your teeth.

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**

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*Pre-determination* is recommended for this service. See Section 8.0 -definition of *pre-determination*.

*Medically necessary* orthodontics and related services are covered for *members* under the age of 19.

## **4.0 DENTAL SERVICES NOT COVERED UNDER THIS AGREEMENT**

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### **4.1 Services Not Dentally Necessary**

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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**

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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 Dental Benefits for the age limits applicable to Covered Dental Services.

### **4.3 Services Covered by the Government**

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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**

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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**

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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**

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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**

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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 ([www.oig.hhs.gov/fraud/exclusions/listofexcluded.html](http://www.oig.hhs.gov/fraud/exclusions/listofexcluded.html)) or the Excluded Parties List System website maintained by the U.S. General Services Administration ([www.epls.gov](http://www.epls.gov)).

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#### **4.8 Services Not Performed Within Indicated Time Limitations**

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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.

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#### **4.9 Anesthesia**

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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.

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#### **4.10 Benefits Available from Other Sources**

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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.

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#### **4.11 Charges for Administrative Services**

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This *agreement* does NOT cover:

- *charges* for missed appointments;
- *charges* for completion of *claim* forms; or
- other administrative *charges*.

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#### **4.12 Christian Scientist Practitioners**

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

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#### **4.13 Clerical Errors**

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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.

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#### **4.14 Consultations -Telephone**

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This *agreement* does NOT cover telephone consultations.

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#### **4.15 Cosmetic Services**

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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.

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#### **4.16 Deductibles and Coinsurance**

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

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#### **4.17 Implants**

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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.

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#### **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.

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#### **4.19 Drugs/Medications**

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Injectable or prescription drugs are NOT covered.

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#### **4.20 Experimental/Investigational Services**

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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.

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#### **4.21 New Dental Services**

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

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#### **4.22 Replacement Services**

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

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#### **4.23 Research Studies**

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This *agreement* does NOT cover research studies.

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#### **4.24 Services Performed By Hospital Staff Employees**

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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**

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

#### **4.26 Services Provided By Relatives or Members of Your Household**

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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**

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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)**

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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**

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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**

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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 *benefit 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 the *claim* to:

Blue Cross & Blue Shield of Rhode Island  
Attention: Blue Cross Dental  
P. O. Box 219  
Providence, RI 02901-0219

## **5.1 How Network Dentists Are Paid**

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We pay *network dentists* directly for *covered dental services*. You are responsible for the coinsurance, if any, which may apply to a *covered dental service*. 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* which may apply to a *covered dental service*. It is your obligation to pay a *network dentist* your *coinsurance*. 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**

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You are responsible for paying all *charges* from a *non-network dentist*. We reimburse you up to the *allowance*, less any *coinsurance* which may apply to a *covered dental service* or procedure. 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*.

## **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 National Association of Insurance Commissioners (NAIC). The COB rules have been adopted by the Rhode Island Office of the Health Insurance Commissioner (OHIC). 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**

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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; OR
- length of time each spouse has been covered.

**(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, the *benefits* of any other coverage available because of student enrollment (except accident-only type coverage) 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 *benefit 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*.

**(5.) 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 first insurer  
+       Any remaining *allowable expense* paid by other insurer

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**Total Benefits Payable**

## **6.4 Our Right to Make Payments and Recover Overpayments**

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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**

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### **7.1 Adverse Benefit Determinations**

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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,
- Denial, reduction, termination, or failure to make a payment based on the imposition of a preexisting condition exclusion, a source of injury exclusion, or other limitation on covered benefits, 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**

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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.

You can use the Member Appeal Form, which a Customer Service Representative can provide to you, or you can send us a letter with the information requested above. 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 Dental  
Attn: Appeals  
P. O. Box 219  
Providence, Rhode Island 02901-0219

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**

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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 Dental  
Attn: Appeals  
P. O. Box 219  
Providence, Rhode Island 02901-0219

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:

- an urgent *preauthorization* request for health care services has been denied (see Section 1.6 – Preauthorization for additional information about urgent *preauthorization* requests);
- the circumstances are an *emergency*, or
- you are in an *inpatient* setting.

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 physician 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 *benefit 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**

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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**

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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 7.2 do not apply to *dentally necessity* determinations ( in Section 7.3), *complaints* regarding payments ( in Section 7.2), 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**

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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**

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### **Definitions**

**SUBROGATION** means we can use your right to recover money from a third party who 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

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*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

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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*.

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*, 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 *benefit year* under this *agreement*.

**BENEFIT 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 Dental 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 your *annual maximum benefit*.

**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 *benefit 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 *benefit year* once you have met the *maximum out-of-pocket expense*.

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

**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*.

**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).

**PREDETERMINATION** is an administrative procedure whereby your *dentist* sends to us your treatment plan before treatment is rendered. *Pre-determinations* are an estimate, not a guarantee of payment. The *pre-determination* 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 *pre-determination* 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 *pre-determinations* 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.

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

**SUBSCRIBER/MEMBER** means you and each *eligible person* listed on your application whom we agree to cover.

**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 or TWELVE (12)-MONTH WAITING PERIOD** means the twelve (12) months during which *members* 19 years old or older must be enrolled in the *plan* before benefits become available for covered major restorative services. These services include crowns, inlays, prosthodontic, and surgical services. If you cancel your coverage under this *agreement* and reinstate later, a new *twelve (12)-month waiting period* must pass before benefits are available for covered major restorative services.

**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 person who is subscribing 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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