

Subscriber Agreement

Blue Cross Dental Option 6

**BLUE CROSS
DENTAL**



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.

HealthSource RI – 1-855-683-6759.

DEPENDENT AGE LIMITS

Dependent Age	See Section 2.1 – Who is Eligible for Coverage.
Dependent Children	Children are covered until the first day of the month following their 26 th 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 *calendar 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 *calendar 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*.

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
Annual Maximum Benefit	The maximum amount we pay for covered dental services per member per calendar year.	Unlimited	\$1,200	\$1,200 The annual maximum benefit applies to both network and non-network services combined. If an enrolled member turns 19 years old during the calendar year and continues to be a member under this agreement, this plan will not cover services in excess of the annual maximum benefit listed for "MEMBERS 19 YEARS OLD AND OLDER". Services previously provided, during a calendar year, are counted in determining whether the annual maximum benefit has been met.	
Maximum Out-of-Pocket Expense The coinsurance amounts apply to the maximum out-of-pocket expense. The annual maximum out-of-pocket expense applies to network services only.	Individual	\$350	N/A	N/A	N/A
	Family - The calendar year family maximum out-of-pocket expense is met by adding the amount of covered dental care expenses applied to the maximum out-of-pocket expense for members under the age of 19; however no one (1) family member can contribute more than \$350 towards the calendar year family maximum out-of-pocket expense.	\$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 dentist	Non-network dentist	Network dentist	Non-network dentist
	NOTE: If an enrolled <i>member</i> turns 19 years old during the <i>calendar 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>calendar 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:
Diagnostic and Preventive Services					
<ul style="list-style-type: none"> Oral Evaluations 	One examination per <i>calendar 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>calendar year</i> .	N/A	N/A	0%	0%
	Two examinations per <i>calendar 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>calendar year</i> .	0%	0%	N/A	N/A

Service Type, Dentist, or Place of Service	Benefit Limit	MEMBERS UNDER THE AGE OF 19		MEMBERS 19 YEARS OLD AND OLDER	
		Network dentist	Non-network dentist	Network dentist	Non-network dentist
	NOTE: If an enrolled member turns 19 years old during the <i>calendar 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>calendar 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"> X-rays 	Single x-rays limited to 4 per 6 month period.	0%	0%	0%	0%
	Bitewing limited to one (1) set per <i>calendar 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%	0%	0%
<ul style="list-style-type: none"> Cleanings (Prophylaxis) 	Two (2) cleanings per <i>calendar year</i> .	0%	0%	0%	0%
<ul style="list-style-type: none"> Fluoride Treatments 	Two (2) fluoride treatment for <i>members</i> under 19 years old per <i>calendar year</i> .	0%	0%	Not Covered	Not Covered
<ul style="list-style-type: none"> Sealants 	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"> Space Maintainers 		0%	0%	20%	20%
Basic Dental Services					
<ul style="list-style-type: none"> Palliative Treatment 	Minor treatment to relieve sudden, intense pain.	50%	50%	20%	20%
<ul style="list-style-type: none"> Fillings 	See Section for details.	50%	50%	20%	20%
<ul style="list-style-type: none"> Simple Extractions 	Removal of erupted tooth (non-surgical).	50%	50%	20%	20%

Service Type, <i>Dentist</i> , 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>
	NOTE: If an enrolled <i>member</i> turns 19 years old during the <i>calendar 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>calendar 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:
<ul style="list-style-type: none"> Denture Repairs and Relines/Rebasing 	Full or partial dentures. Relines/Rebasing limited to once in a 60-month period.	50%	50%	20%	20%
Major Dental Services					
<ul style="list-style-type: none"> Crowns & Onlays 	Replacement is limited to once in a 60 month period. <i>Predetermination</i> is recommended.	50%	50%	50%	50%
<ul style="list-style-type: none"> Therapeutic Pulpotomies 	Limited to <i>members</i> under 14 years old.	50%	50%	Not Covered	Not Covered
<ul style="list-style-type: none"> Root Canal Therapy - Anterior(front) Teeth 		50%	50%	20%	20%
<ul style="list-style-type: none"> Root Canal Therapy - Posterior (back)Teeth 		50%	50%	20%	20%
<ul style="list-style-type: none"> Non-Surgical Periodontal Services 		50%	50%	50%	50%
<ul style="list-style-type: none"> Surgical Periodontal Services 	<i>Predetermination</i> is recommended.	50%	50%	50%	50%
<ul style="list-style-type: none"> Periodontal Maintenance 	Limited to two (2) services in a <i>calendar year</i> .	50%	50%	50%	50%

Service Type, <i>Dentist</i> , 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>
	NOTE: If an enrolled <i>member</i> turns 19 years old during the <i>calendar 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>calendar 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:
<ul style="list-style-type: none"> Fixed Bridges and Dentures 	Coverage for replacements limited to one (per tooth/unit) in a 60-month period. Crowns over implants are considered a prosthodontic service. <i>Predetermination</i> is recommended.	50%	50%	50%	50%
<ul style="list-style-type: none"> Single Tooth Implant 	Coverage if placed as an alternative treatment to a conventional 3-unit bridge. Replacing only one missing tooth. Coverage for replacements limited to one (1) in a 60-month period.	50%	50%	50%	50%
Oral Surgery Services	Limited to coverage when services are not covered under the member's medical insurance.				
<ul style="list-style-type: none"> General Anesthesia or IV Sedation 	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"> Oral Surgery Services 		50%	50%	20%	20%

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 dentist	Non-network dentist	Network dentist	Non-network dentist
	NOTE: If an enrolled member turns 19 years old during the <i>calendar 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>calendar 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:
• Biopsies	Limited to the biopsy and examination of oral tissue, soft or hard.	50%	50%	20%	20%
Occlusal (Night) guards	Limited to one (1) every five (5) years.	50%	50%	Not Covered	Not Covered
Orthodontic Services (Braces)	<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
Subscriber Agreement**

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1.0 INTRODUCTION

1.1 Agreement and Its Interpretation

Our entire contract with you consists of this *agreement* and our *agreement* with your *employer/agent*. A determination will be made regarding your eligibility for *benefits* and the provisions of this *agreement* will be construed subject to your right to appeal or to take legal action as described in Section 7.0.

This *agreement* may be changed by us or by your *employer/agent*. 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 your *employer/agent*.

This *agreement* shall be construed under and shall be governed by the applicable laws and regulations of the State of Rhode Island and federal law as amended from time to time.

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

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

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

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

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

1.3 Words With Special Meaning

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

The sections below also define certain words and phrases:

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

1.4 You and Blue Cross & Blue Shield of Rhode Island

We, Blue Cross & Blue Shield of Rhode Island, agree to provide coverage for *dentally necessary covered dental care services* listed in this *agreement*.

We only cover a service in this *agreement* if it is *dentally necessary*. We review dental necessity per our dental policies and related guidelines. The term *dentally necessary* is defined in Section 8.0 - Glossary. It does not include all dentally appropriate services.

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

This *agreement* provides coverage for dental services that we have reviewed and determined are eligible for coverage based on our dental policies and related guidelines. Dental services which we have not reviewed are not covered under this *agreement*. Dental services which we have reviewed and determined are not eligible for coverage are not covered under this *agreement*. If a service or category of service is not listed as covered, it is not covered under this *agreement*. Section 3.0 lists the dental services covered under this *agreement* along with their related exclusions. Section 4.0 lists general exclusions.

Genetic Information

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

We will not:

- adjust premiums based on genetic information;
- request or require an individual or family *members* of an individual to have a genetic test; or
- collect genetic information from an individual or family *members* of an individual before or in connection with enrollment under this *agreement* or at any time for underwriting purposes.

1.5 Customer Service/General Information

If you have questions about your *benefits* under this *agreement*, call the Blue Cross & Blue Shield of Rhode Island (BCBSRI) Customer Service Department at (401) 453-4700 or 1-800-831-2400 or Voice TDD 711. Our normal business hours are Monday - Friday from 8:00 a.m. - 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.

1.6 Our Right to Receive and Release Information About You

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

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

Our release of information about you is regulated by law. Please see the Rhode Island Confidentiality of Health Care Communications and Information Act, §§ 5-37.3-1 et seq. of the Rhode Island General Laws, the Health Insurance Portability and Accountability Act Final Privacy Regulations, 45 C.F.R. §§ 160.101 et seq., the Gramm-Leach-Bliley Financial Modernization Act, 15 U.S.C. §§ 6801-6908, and Regulation 100 adopted by the Rhode Island Office of the Health Insurance Commissioner (OHIC).

1.7 Our Right to Conduct Utilization Review

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

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

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

1.8 Your Right to Choose Your Own Dentist

Your relationship with your *dentist* is very important. This *agreement* is intended to encourage the relationship between you and your *dentist*. However, we are not obligated to provide you with a *dentist*. Also, we are not liable for anything your *dentist* does or does not do. We are not a dental provider. We do not practice dentistry, furnish dental care, or make dental judgments.

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

- constitute *dentally necessary* services for the purpose of benefit payment; and

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

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

1.9 Your Responsibility To Pay Your Dentist

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

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

2.0 ELIGIBILITY

Your *employer* may purchase this *agreement* directly from us or from *HealthSource RI*.”

- If your *employer* purchased this *agreement* directly 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 your *employer* and *HealthSource RI*]. Please contact your *employer* or *HealthSource RI* at 1-855-683-6759 for questions about your eligibility.

2.1 Who is an Eligible Person

You: You are eligible to enroll in coverage under this *agreement* provided that you:

- meet the minimum work-hour requirements; and
- have satisfied the waiting period, if any, of your *employer/agent*.

The date on which you have met your *employer’s/agent’s* eligibility requirements and are entitled to apply for coverage under this *agreement* is your eligibility date.

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: Provided your employer/agent authorizes the eligibility of domestic partners, your domestic partner is eligible to enroll for coverage under this agreement. You and your domestic partner must complete and sign our Declaration of Domestic Partnership and we must receive necessary proof. Please contact your employer/agent for additional information regarding coverage for domestic partners.
- 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 26th birthday. For purposes of determining eligibility under this *agreement*, the term child means:

- Natural Children;
- Step-children;
- Legally Adopted Children: In accordance with Rhode Island General Law § 27-20-14, an adopted child will be considered eligible for coverage as of the date of placement for adoption with you by a licensed child placement agency;
- Foster Children: Your foster children who permanently live in your home are eligible to enroll for coverage under this *agreement*.

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

Disabled Dependents

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

When You Can Enroll or Make Changes

When you are first eligible, you and your eligible dependents may enroll by completing an application through your *employer/agent* within the first thirty-one (31) days following your eligibility date. So long as we receive your membership application within that timeframe and your membership fees are paid, your coverage begins on the first day of the month following your eligibility date.

If you or your dependents fail to enroll at this time, you cannot enroll in the *plan* unless you do so through an Open Enrollment Period or a Special Enrollment Period.

Open Enrollment Period

An Open Enrollment Period will be held each year for coverage to be effective on the first day of the *plan year*. You and/or your eligible dependents may enroll at this time by completing an application during the open enrollment period.

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 thirty (30) 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 private health insurance coverage, you may enroll or add your eligible dependents for coverage through a Special Enrollment Period by completing a written application within thirty (30) 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, or
- 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 either the first day of the month following the event or, if the event occurs on the first day of a month, coverage under this plan begins on 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 thirty (30) 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 *HealthSource RI*, at 1-855-683-6759 for questions about these Special Enrollment Periods and your eligibility within thirty (30) days following the Special Enrollment event.

- 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; or
 - 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 *HealthSource RI*, in accordance with guidelines issued by U.S. Department of Health and Human Services (HHS), 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; or
 - 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 notify your *employer/agent* if you want to add family *members* according to the provisions described above in Section 2.2.

If you want to remove family *members* from your coverage, you must notify your *employer/agent* in advance of the requested removal date and your *employer/agent* must send notification to us.

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:

- if you leave your place of work;
- if you decide to discontinue coverage, we, your *employer/agent*, or *HealthSource RI* must receive notice to end this *agreement* fourteen (14) days prior to the requested date of cancellation. If we do not receive your notice prior to the requested date of cancellation, you or your *employer/agent* may be responsible for paying another month's premium;
- if you or your *employer/agent* does not pay any required membership fees within one month of the date they are due. If your *employer/agent* does not pay the required fees, the termination will be effective five (5) days after we mail you a notice of discontinuance;
- if you cease to be an *eligible person*;
- if we cease to offer this type of coverage;
- for a covered dependent if the dependent no longer qualifies as an eligible dependent;
- if you change from one plan to another plan during an Open Enrollment or Special Enrollment Period;
- if your *employer/agent* contracts with another insurer or entity to provide or administer benefits for the *covered dental care services* provided by this *agreement*, your group's agreement with us will end. You will not be offered membership in our direct dental plan;
- if fraud is determined by us. Fraud includes, but is not limited to, misuse of your identification card (ID card) and any misrepresentation 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 group coverage, or any other coverage that may become available in the future. You will not be offered membership in our direct dental plan; or
- if abuse or disregard for *dentist* protocols and policies is determined by us. If after making a reasonable effort *dentists* are unable to establish or maintain a satisfactory relationship with a member, coverage may be terminated after 31-days' written notice. Examples of unsatisfactory *dentist*-patient relationships include:
 - abusive or disruptive behavior in a *dentist's* office;
 - repeated refusals by a *member* to accept procedures or treatment recommended by a *dentist*; and
 - impairing the ability of the *dentist* to provide care.

You will not be offered membership in our direct dental plan.

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

When your coverage ends, you will be entitled to apply for direct pay membership from Blue Cross & Blue Shield of Rhode Island or through the RI Health Benefit Exchange. You must meet the eligibility requirements. We must receive an application and membership fees within sixty (60) days from the date your group membership ends. If you do not reside in Rhode

Island, you do not qualify to enroll in our direct pay plans. You may be able to obtain coverage through an insurance company in the state in which you reside.

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.

2.5 Continuation of Coverage

If your coverage is terminated you may be eligible to continue your coverage in accordance with federal law.

Continuation of Coverage According to Federal Law

If coverage under this *agreement* for you or your covered dependents is terminated and your coverage was made available through the group dental *plan* of an *employer/agent* of 20 or more employees, you may continue to be eligible for coverage according to federal law. This law is the Consolidated Omnibus Budget Reconciliation Act of 1986 as amended from time to time (“*COBRA*”). Your *employer/agent* is responsible for making *COBRA* coverage available to you, and for complying with all of *COBRA*'s requirements. The information provided below is a general summary of the *COBRA* requirements in place when this *agreement* was drafted and should not be relied upon when making coverage decisions. You should contact your *employer/agent* if you have any questions about *COBRA*.

Qualifying Events: In order to be eligible for *COBRA* continuation, you need to have experienced a Qualifying Event. A Qualifying Event is one of the events listed below which would result in loss of coverage if not for the *COBRA* continuation:

- (a) The death of the covered employee.
- (b) The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment.
- (c) The divorce or legal separation of the covered employee from the employee's spouse.
- (d) The covered employee becoming entitled to *benefits* under (enrolled in) Medicare.
- (e) A dependent child ceasing to be a dependent child under the generally applicable requirements of the *plan*.
- (f) A bankruptcy proceeding with respect to the *employer/agent* from whose employment the covered employee retired at any time. In the case of a bankruptcy, a loss of coverage includes a substantial elimination of coverage within one year before or after the date of commencement of the proceeding.

- (g) Employees who leave civilian employment positions to perform active duty military service in the United States Uniformed Services.

Election: If you are eligible for *COBRA* continuation and you experience a Qualifying Event, you must make an election with your *employer/agent* for *COBRA* continuation coverage to begin. Your *employer/agent* will contact you and provide you with an opportunity to elect *COBRA* continuation if you would lose coverage due to (a), (b), (d), or (f) above. If you experience the event listed in (c), (e), or (g) you must notify your *employer/agent* within 60 days in order for your *employer/agent* to send election forms.

Premium: You must pay premiums in order to continue to be covered. *COBRA* continuation coverage is generally at 102% of the applicable premium, or 150% of the applicable premium during the period of extended continuation due to disability as described below. Your *employer/agent* will notify you of the specific applicable premium.

Duration of Coverage: *COBRA* continuation may continue until the earlier of the following events:

1. The date on which the maximum period of coverage is exhausted. The maximum periods of coverage are:
 - 18 Months if *COBRA* continuation is available due to Qualifying Event (b).
 - 24 months while serving active duty military service if *COBRA* continuation is available due to Qualifying Event (g).
 - 36 Months if *COBRA* continuation is available due to Qualifying Events (a), (c), (d), (e), or (f).
 - Extension for disability: In the case you or one of your dependents is determined, under title II or XVI of the Social Security Act, to have been disabled at any time during the first 60 days of continuation coverage, the maximum period may be extended from 18 months to 29 months (with respect to you and all of your covered dependents). To qualify for this extension you must provide a copy of the Social Security ruling letter to the *employer/agent* within 60 days of receipt, but prior to the expiration of the 18 months.
2. The date on which the *employer/agent* ceases to provide any group dental *plan* to any employee.
3. The date on which coverage ceases due to the failure to pay any required premium when due.
4. The date on which the covered person becomes covered on another group dental *plan* that does not contain a pre-existing conditions clause for which the covered person does not have sufficient creditable coverage.
5. The date on which the covered person becomes entitled to (enrolled in) Medicare coverage.
6. In the event coverage is extended for up to 29 months due to disability, the first day of the month during such period of extension in which the covered person is determined to no longer be disabled.

If you have any questions regarding *COBRA* continuation, you are encouraged to contact your *employer/agent*.

3.0 COVERED DENTAL SERVICES

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

3.1.1 Oral Evaluations

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

3.1.2 X-rays

We cover one (1) set of bitewing x-rays per *calendar 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 once per sixty (60) month period. X-rays other than those listed above are covered.

3.1.3 Cleanings

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

3.1.4 Fluoride

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

3.1.5 Sealants

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

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

3.2 BASIC DENTAL SERVICES

3.2.1 Minor Treatment For Acute Dental Pain

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

3.2.2 Fillings

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

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

3.2.4 Denture or Partial Repairs

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

3.3 MAJOR DENTAL SERVICES

3.3.1 Crowns and Onlays

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*.

3.3.2 Root Canal Therapy

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

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

Non-Surgical Periodontal services are covered. Periodontic maintenance following documented periodontal surgery is covered up to two (2) times per *calendar 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

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*.

3.3.5 Prosthodontics

Fixed bridges and partial or complete dentures are covered services. 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. This *agreement* covers a single tooth implant as a prosthodontic service.

3.3.6 Biopsies

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

3.3.7 Oral Surgery

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

Occlusal guards are covered for *members* under the age of 19. 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

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

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

4.0 DENTAL SERVICES NOT COVERED UNDER THIS AGREEMENT

4.1 Services Not Dentally Necessary

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

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

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

4.2 Services Not Listed in Section 3.0

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

4.3 Services Covered by the Government

This *agreement* does NOT cover:

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

4.4 Services and Supplies Mandated by Laws in Other States

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

4.5 Services Provided By College/School Facilities

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

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

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

4.7 Services Performed by Excluded Providers

This *agreement* does NOT cover dental services performed by a *dentist* who has been excluded or debarred from participation in Federal programs such as Medicare and Medicaid. To determine whether a *dentist* has been excluded from a Federal program, visit the U.S. Department of Human Services Office of Inspector General website (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).

4.8 Services Not Performed Within Indicated Time Limitations

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

4.9 Anesthesia

This *agreement* does NOT cover:

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

4.10 Benefits Available from Other Sources

This *agreement* does NOT cover:

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

4.11 Charges for Administrative Services

This *agreement* does NOT cover:

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

4.12 Christian Scientist Practitioners

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

4.13 Clerical Errors

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

4.14 Consultations -Telephone

This *agreement* does NOT cover telephone consultations.

4.15 Cosmetic Services

This *agreement* does NOT cover cosmetic procedures.

Cosmetic procedures are performed:

- to refine or reshape dental structures that are not functionally impaired;
- to change or improve appearance or improve self-esteem; or
- for other psychological, psychiatric or emotional reasons.

4.16 Deductibles and Coinsurance

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

4.17 Implants

This *agreement* does NOT cover:

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

4.18 Employment-Related Injuries

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

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

However, if your employer is self-insured against Workers' Compensation liabilities pursuant to a Rhode Island group or individual self-insurance plan for which we provide administrative claims management services, to the extent required by our contract with such plan, we process bills and payments for dental services arising out of work-related illnesses, conditions, or injuries covered by such plan as if the services were covered under this agreement. Although we provide administrative claims management services only, for the purposes of any participating contract between us and a dentist, you will be deemed to be a subscriber receiving services performed under this agreement.

4.19 Drugs/Medications

Injectable or prescription drugs are NOT covered.

4.20 Experimental/Investigational Services

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

4.21 New Dental Services

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

4.22 Replacement Services

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

4.23 Research Studies

This *agreement* does NOT cover research studies.

4.24 Services Performed By Hospital Staff Employees

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

4.25 Services Completed Prior To The Effective Date

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

4.26 Services Provided By Relatives or Members of Your Household

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

4.27 Specialty Oral Examinations

We will NOT cover oral examinations (limited in scope) when performed by a *dentist* who limits his or her practice to a specialty branch of dentistry. This includes, but is not limited to, oral examinations relating to periodontics, orthodontics, endodontics, oral surgery, and prosthodontics.

4.28 Temporomandibular Joint Syndrome (TMJ)

This *agreement* does NOT cover:

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

4.29 Travel Expenses

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

5.0 HOW YOUR COVERED DENTAL SERVICES ARE PAID

Payments we make to you are personal and you cannot transfer or assign any of your right to receive payments under this *agreement* to another person or organization.

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

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

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

Our payments to you or the *dentist* fulfill our responsibility under this *agreement*. In accordance with Rhode Island General Law § 27-20-49, benefits may be assigned and with your written consent our payments can be made to a *non-network dentist*. Your benefits, however, are personal to you and cannot be assigned, in whole or in part, to another person or organization.

Network dentists file *claims* for you and must do so within one year of providing a *covered dental service* to you.

Non-network dentists may or may not file *claims* for you. If the *non-network dentist* does not file the *claim* on your behalf, you will need to file the *claim* yourself. To file a *claim*, please send us an itemized bill including the following:

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

Please mail 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

We pay *network dentists* directly for *covered dental services*. You are responsible for the *coinsurance* or *deductibles*, 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* and *deductible* which may apply to a *covered dental service*. It is your obligation to pay a *network dentist* your *coinsurance* and *deductible*. If you do not pay the *network dentist*, the *dentist* may decline to provide current or future services or may pursue payment from you. See Section 1.9 – Your Responsibility to Pay Your *Dentists* for more information.

5.2 How Non-Network Dentists Are Paid

You are responsible for paying all *charges* from a *non-network dentist*. We reimburse you up to the *allowance*, less any *coinsurance* and/or *deductible* 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

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 *calendar year*, not the year in which the person was born. If the other *plan* does not determine *benefits* according to the parents' birth dates, but by parents' gender instead, the other *plan's* gender rule will determine the order of *benefits*.

(3.) Dependent Child/Parents Separated or Divorced - If two or more *plans* cover a person as a dependent child of divorced or separated parents, the *plan* responsible to cover *benefits* for the child will be determined in the following order:

- first, the *plan* of the parent with custody of the child;
- then, the *plan* of the spouse of the parent with custody of the child; AND
- finally, the *plan* of the parent not having custody of the child.

If the terms of a court decree state that one of the parents is responsible for the dental care expenses of the child, and the entity obligated to pay or provide the parent's *benefits* under that parent's *plan* has actual knowledge of those terms, the *benefits* of that *plan* are determined first and the *benefits* of the *plan* of the other parent are the *secondary plan*.

If the terms of a court decree state that the parents share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the *plans* covering the child will follow the order of benefit determination rules outlined in Section 6.3 (2) above.

(4.) Active/Inactive Employee - If you are covered under another dental *plan* as an employee (not laid off or retired), your *benefits* and those of your dependents under that *plan* will be determined before benefits under this *plan*.

(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

Total Benefits Payable

6.4 Our Right to Make Payments and Recover Overpayments

If payments which should have been made by us according to this provision have actually been made by another organization, we have the right to pay those organizations the amounts we decide are necessary to satisfy the rules of this provision. These amounts are considered *benefits* provided under this *agreement* and we are not liable for them.

If we have made payments for *allowable expenses* which are more than the maximum amount needed to satisfy the conditions of this provision, we have the right to recover the excess amounts from: the person to or for whom the payments were made; any other insurers; and/or any other organizations (as we decide). As the *subscriber*, you agree to pay back any excess amount, provide information and assistance, or do whatever is necessary to recover this excess amount. When determining the amount of payments made we include the reasonable cash value of any *benefits* provided in the form of services.

7.0 ADVERSE BENEFIT DETERMINATION AND APPEALS

7.1 Adverse Benefit Determinations

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

- Denial of a benefit (in whole or part),
- Reduction of a benefit,
- Termination of a benefit,
- Failure to provide or make a payment (in whole or in part) for a benefit,
- 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

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

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 *calendar year*. We will refund you if the denial is reversed and will waive the fee if it imposes an undue hardship on you.

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

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

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

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

7.4 Legal Action

If you are dissatisfied with the decision on your claim, and have complied with applicable state and federal law, you are entitled to seek judicial review. This review will take place in an appropriate court of law.

Note: *Once a member or dentist receives a decision at one of the several levels of appeal (Level 1, Level 2, External, and Legal Action), the member or dentist may not ask for an appeal at the same level again, unless additional information that could impact such decisions can be provided.*

Under state law, you may not begin court proceedings prior to the expiration of sixty (60) days after the date you filed your claim. In no event may legal action be taken against us later than three (3) years from the date you were required to file the claim (see Section 6.1).

For *members* covered by a group (employer sponsored) health plan, your plan may be subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Under federal law, if your plan is subject to ERISA you may have the right to bring legal action under section 502(a) of ERISA after you have exhausted all available administrative appeals. For appeals other than dental appeals, federal law requires that you pursue a final decision on an administrative appeal prior to filing suit under section 502(a) of ERISA. For dental appeals, federal law requires that you pursue a Level 2 review prior to filing a suit under section 502(a) of ERISA. You are not required to submit your claim to external review prior to filing a suit under section 502(a) of ERISA. Consult your employer to determine whether this applies to you and what your rights and obligations may be. 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.

7.5 Grievances Unrelated to Claims

We encourage you to discuss any *complaint* that you may have about any aspect of your dental treatment with the *dentist* that furnished the care. In most cases, issues can be more easily resolved when they are raised when they occur. If, however, you remain dissatisfied or prefer not to take up the issue with your *dentist*, you may access our *complaint* and grievance procedures.

You may also access our *complaint* and grievance procedures if you have a *complaint* about our service or about one of our employees. In order to start a grievance, please call our Customer Service Department at (401) 453-4700 or 1-800-831-2400. The Customer Service Department will log in your call and begin working towards the resolution of your *complaint*.

The grievance procedures described in this Section 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

We have the right to withhold payment during the period of investigation on any *claim* we receive that we have reason to believe might not be eligible for coverage. We will also conduct pre-payment review on a *claim* we have reason to believe has been submitted for a service not covered under this *agreement*. We will make a final decision on these *claims* within sixty (60) days after the date you filed the *claim*.

We also have the right to perform post-payment reviews of *claims*. If we determine misrepresentation was used when you filed the *claim*, or if we conclude that a *claim* should not have been paid for any reason, we may take all necessary steps (including legal action) to recover funds paid to you or to a *dentist*.

7.7 Our Right of Subrogation and/or Reimbursement

Definitions

SUBROGATION means we can use your right to recover money from a third party 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 *reimbursement*, you must keep an amount equal to our claim in a separate account until the dispute is resolved. If a court orders that money be paid to you or any third party before your lawsuit is resolved, you must tell us quickly so we can respond in court.

Member Cooperation

You must give us information and help us. This means you must complete and sign all necessary documents to help us get money back. You must tell us in a timely manner about the progress of your claim with a third party. This includes filing a claim or lawsuit, beginning settlement discussions, or agreeing to a settlement in principle, etc. It also means that you must give us timely notice before you settle any claim. You must not do anything that might limit our rights under this Section. We may take any action necessary to protect our right of *subrogation* and *reimbursement*.

8.0 GLOSSARY

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

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

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

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

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

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

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

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

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

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

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

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

COINSURANCE means a percentage of our *allowance* that you must pay for certain *covered dental services*. See the Summary of 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*.

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

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

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

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

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

DENTIST means any person duly licensed and registered to practice dentistry as defined in Section 5-31-1 of the General Laws of Rhode Island, as amended. This includes persons duly licensed under comparable laws of other states and countries if *covered dental services* are rendered at the time and place that comparable laws are effective. The services must be performed within the scope of the individual's license.

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

EMPLOYER/AGENT means any individual, corporation, association or college or university that pays for some or all of your membership and benefits as described in this *agreement*. This person or company is separate from us. Membership applications may be prepared by you and delivered to us by your *employer/agent*.

HEALTHSOURCE RI means a Rhode Island governmental agency that makes Qualified Health *Plans* (QHPs) available to qualified individuals. 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 *calendar 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 *calendar 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).

PLAN YEAR means the one-year period that begins on the anniversary date of your *employer/agent's* group agreement.

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.

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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Plan = On/Off Exchange QDP SGOOE BCD OPT 6 v1.15



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