Subscriber Agreement

RI Laborers Health Fund
Group #’s 6820-0001, 6820-0002, 6820-0003 & 6820-0005

This plan does not provide pediatric dental services in accordance with the Affordable Care Act (ACA) or as covered in the essential health benefits (EHB) benchmark plan.

Blue Cross Blue Shield of Rhode Island

BLUE CROSS & BLUE SHIELD OF RHODE ISLAND
SUBSCRIBER AGREEMENT

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INTRODUCTION TO SUMMARY OF BENEFITS

SUMMARY OF BENEFITS

This is a summary of your dental *benefits* under this *plan*. It includes information about *coinsurance, deductibles, annual maximum benefit*, and *maximum out-of-pocket expenses.* This summary is intended to give you a general understanding of the dental coverage available under this *plan*. Please read Section 3.0 for a detailed description of coverage and the *benefit limit*s for covered *dental services* and Section 4.0 for exclusions.

The amount you pay for *covered dental services* can differ based on the following:

- the *dentist* is a *network dentist* or a *non-network dentist*;
- a *deductible*, *coinsurance*, or *benefit limit* applies;
- the Total Health Solutions enhanced *benefit* applies (see below for details);
- you reached your *annual maximum benefit*;
- you reached your *plan year maximum out-of-pocket expense*; or
- there are exclusions from coverage that apply.

Network Dentist Services
If *you* receive *covered dental services* from a *network dentist,* the *dentist* has agreed to accept our payment for *covered healthcare services* as payment in full, excluding your *coinsurance* and *deductible*, and the difference between the *benefit limit* and our *allowance.*

Non-network Dentist Services
If *you* receive *covered dental services* from a *non-network dentist*, *you* will be responsible for the *dentist's charge*. *You* will be reimbursed based on the lesser of our *allowance*, the *non-network dentist's charge*, or the *benefit limit*, less any *copayments* and *deductibles*. The *deductible, maximum out-of-pocket expenses,* and *annual maximum benefit* are calculated based on the lower of our *allowance* or the *dentist's charge*, unless otherwise specifically stated.

Total Health Solutions

Total Health Solutions is a program which allows for a more comprehensive treatment of certain health conditions by providing enhanced dental *benefits* for the following services:

- Non-Surgical Periodontal Services and Periodontal Maintenance - a *coinsurance* is not required for these services when *members* have been diagnosed with diabetes and/or coronary artery disease.
- Cleanings (Prophylaxis) - besides the two (2) cleanings provided per *plan year*, *members* who are pregnant are also provided one (1) additional cleaning during their pregnancy.

To determine if you or your enrolled dependent(s) are eligible for any of these enhanced dental *benefits* please contact Blue Cross Dental Customer Service or visit our website for details. Please note: Total Health Solutions enhanced *benefits* are not available until you have received confirmation from us.

Deductible/Annual Maximum Benefits/Orthodontic Lifetime Maximum

Benefit Description	***Network Providers*** **You Pay**	***Non-network Providers*** **You Pay**
Deductible In the Summary of Benefits below, services subject to the *deductible* are indicated with "after *deductible*". The *deductible* applies to both *network* and *non-network* services combined.		
Single: Family:	None None	
Annual Maximum Benefit		
The maximum amount we pay for *covered dental services* per *member* per calendar year. The *annual maximum benefit* applies to both *network* and *non-network* services combined. The annual maximum benefit applies to all covered services except the following oral surgery services: • surgical removal of partially bony impactions, • surgical removal of completely bony impactions, • surgical removal of completely bony impactions with unusual surgical complications; and • apicoectomies.	$2,000	
Orthodontic Lifetime Maximum Benefit		
The maximum amount we pay for *covered dental services* per *member* per lifetime for orthodontics (braces). Separate from the *annual maximum benefit*	$2,000	

SUMMARY OF BENEFITS

Covered Dental Benefits	**Network Dentists You Pay**	**Non-network Dentists You Pay**
See Section 3 – *Covered Dental Services* for additional *benefit limits* and coverage information.		
Dental Services		
See Section 3 - Covered Dental Services for additional *benefit limits* and details.		For *non-network dentists* you pay the amount specified below plus the difference between the *charge* amount and the *allowance*.
***Predetermination is recommended for this service. See Section 5 for more information.**		
Basic Preventive and Diagnostic Services		
Oral Evaluations		
One (1) examination per calendar year.	0%	0%
Cleanings (prophylaxis)		
Two (2) cleanings per calendar year. Besides these [two (2)] cleanings provided per *plan year*, *members* who are pregnant are also provided [one (1)] additional cleaning during their pregnancy.	0%	0%
X-rays		
Single x-rays as needed.	0%	0%
Bitewing set is limited to one (1) set per calendar year.	0%	0%
Limited to one full mouth series (FMX) or panorex per 36-month period.	0%	0%
Fluoride treatments		
One (1) fluoride treatment for *members* under nineteen (19) years old per calendar year.	0%	0%
Sealants		
Limited to one per tooth in a 24-month period for *members* under eighteen (18) years old.	0%	0%
Denture Repairs, Reline, and Rebasing		
Relines/Rebasing limited to once in a thirty-six (36) month period.	0%	0%
Space maintainers:		
For primary (baby) teeth lost prematurely, for members under age 14.	0%	0%
Palliative treatment:		
	0%	0%
Minor Restorative Services		
Fillings:		
Replacement fillings are covered after a 24-month period.	0%	0%
Recementations		
	0%	0%
Simple extractions		
	0%	0%
Therapeutic Pulpotomies (*)		
	0%	0%

Covered Dental Benefits	Network Dentists You Pay	Non-network Dentists You Pay
Biopsies (*)		
	0%	0%
Root canal therapy (*)		
	0%	0%
Non-surgical periodontal services and periodontal maintenance (*)		
Limited to four (4) periodontal maintenance services in a calendar year.	0%	0%
Total Health Solutions - members diagnosed with diabetes and/or coronary artery disease. See Total Health Solutions for details.	0%	0%
Major Restorative Services		
Crowns & onlays (*)		
Replacement is limited to once in a 60-month period.	0%	0%
Oral surgery services (*)		
	0%	0%
General anesthesia or IV sedation – dental office (*)		
	0%	0%
Surgical periodontal services (*)		
	50%	50%
Prosthodontics		
Bridges and dentures (*)		
Coverage for replacements limited to one (per tooth/unit) in a 60-month period.	50%	50%
Single tooth implant (*)		
Coverage for replacements limited to one (1) in a 60-month period.	50%	50%
Orthodontics		
Orthodontic services (braces) (*)		
	50%	50%

SECTION 1: INTRODUCTION TO YOUR SUBSCRIBER AGREEMENT

Thank you for choosing Blue Cross & Blue Shield of Rhode Island (BCBSRI) for your dental coverage. We appreciate the trust you've placed in us and want to help you make the most of your dental *plan*.

In this *Subscriber Agreement* (*agreement*), you'll find valuable information about your *plan*, including:

- how your dental coverage works;
- how BCBSRI processes *claims* for the dental services you receive;
- your rights and responsibilities as a BCBSRI *member;*
- BCBSRI's rights and responsibilities.

We encourage you to read this *agreement* to learn about all the advantages of being a BCBSRI *member*.

How to Use This Agreement

Below are some helpful tips on how to find what you need in this *agreement*.

- As a *member*, you are responsible for understanding the *benefits* to which you are entitled under this *agreement* and the rules you must follow to receive those *benefits*.
- The Table of Contents will help you find the order of the sections as they appear in the *agreement*.
- The Summary of *Benefits*, included in this *agreement*, shows the amount you pay out of your own pocket.
- Section 3: *Covered Dental Services* shows the *benefit limits* that may apply to *covered dental services*.
- Important contact information, such as, telephone numbers, addresses, and websites are located at the end of this document.
- 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. Please see Section 8 for definitions of these words.
- When we use the words "we," "us," and "our," we are referring to BCBSRI. When we use the words "you" and "your" we are referring to the enrolled *subscriber* and/or *member*. These words are also defined in the Glossary.
- Many sections of this document are related to other sections. You may need to reference more than one section to find the information you need.

Contact Us If You Have a Question

If you have questions about your *benefits* or anything in this *agreement*, we are happy to help. Simply call Blue Cross Dental Customer Service or visit one of our Your Blue Store locations. As a BCBSRI *member*, you may also log in to our secure *member* website to find out BCBSRI news, get *plan* information or use many of our self-service options.

Your Member Identification Card

Your BCBSRI *member* identification (ID) card is your key to getting dental coverage. All BCBSRI *members* receive ID cards, which provide important information about your coverage. This card is for identification only, and you must show it whenever you receive dental services. Please note you must be a current *member* to receive covered services.

Tips for keeping your card safe:

- Carry it with you at all times.
- Keep it in a safe location, just as you would with a credit card or money.
- Let BCBSRI know right away if it is lost or stolen.

Your Guide to Selecting a Dentist

Quality dental care begins with a partnership between you and your *dentist*. When you need care, call your *dentist*, who will help coordinate your care.

How to Find a Dentist

Finding a *dentist* in our *network* is easy. To select a *dentist*, or to check that a *dentist* is in our *network*, please use the "Find a Doctor" tool on our website or call Blue Cross Dental Customer Service.

We encourage you to become involved in your dental care by asking your *dentist* about all treatment plans available and their costs. You can also take advantage of the preventive dental services offered under this *plan* to help you stay healthy and find problems before they become serious.

Please note: We are not obligated to provide you with a *dentist*. We are not liable for anything your *dentist* does or does not do. We are not a healthcare provider and do not practice medicine, dentistry, furnish health care, or make medical judgments.

Programs to Keep You Healthy

From time to time, we may offer you programs intended to help you make positive changes to your lifestyle and keep you healthy at no additional cost. These may involve providing credits toward your *plan* premium or a reduction or waiver of *deductible* and/or *coinsurance* for certain *covered dental services*, as permitted by applicable state and federal law. Your participation in these programs is voluntary. We reserve the right to change or stop providing these programs at any time.

> Additionally, we may offer you coupons, discounts, or other incentives as part of our *member* incentives program. These coupons, discounts and incentives are not *benefits* and do not change or affect your *benefits* under this *plan*. You must be a *member* to be eligible for *member* incentives. Restrictions may apply to these incentives, and we reserve the right to change or stop providing *member* incentives at any time.

About This Agreement

Our entire contract with you consists of this *agreement* and our contract with *y*our employer. *Y*our ID card will identify you as a *member* when you receive the healthcare services covered under this *agreement*. By presenting *y*our ID card to receive *covered dental services*, you are agreeing to abide by the rules and obligations of this *agreement*.

*Y*our eligibility for *benefits* is determined under the provisions of this *agreement*. *Y*our right to appeal and take action is described in Appeals in Section 5.

This *agreement* describes the *benefits*, exclusions, conditions and limitations provided under *y*our *plan*. It 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. It replaces any *agreement* previously issued to you. If this *agreement* changes, an amendment or new *agreement* will be provided.

SECTION 2: ELIGIBILITY

This section describes:

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

Who Is an Eligible Person

You

You are eligible for coverage if you are an employee and have met your employer's eligibility requirements, including any waiting period.

Your Spouse

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

- Your legal spouse: according to the laws of the state in which you were married.
- Your common law spouse: according to the law of the state in which your marriage was formed. To be eligible, you and your common law spouse need to complete our Affidavit of Common Law Marriage and provide us with the required documentation listed on the affidavit. Please call Blue Cross Dental Customer Service to obtain a copy.
- Your civil union partner: according to the law of the state in which you entered into a civil union. Civil union partners may only be enrolled if civil unions are recognized by the state in which you reside.
- Former Spouse: In the event of a divorce, your former spouse can continue to be eligible for coverage provided that your divorce decree requires it in accordance with state law. Your former spouse will remain eligible on your policy until the earlier of:
  - the date either you or your former spouse are remarried;
  - the date provided by the judgment of divorce; or
  - the date your former spouse has comparable coverage available through his or her own employment.

Your Children

Each of your and your spouse's children is eligible for coverage until the last day of the month in which they turn twenty-six (26). For purposes of determining eligibility for coverage, the term children means:

- Natural children;
- Step-children;
- Legally adopted children;
- Foster children who have been placed with you by an authorized placement agency or court order.

A child for whom dental coverage is required through a Qualified Medical Child Support Order or other court or administrative order is also eligible for coverage. Your employer is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

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

Disabled Dependents
In accordance with R.I. General Law § 27-20-45, when your enrolled unmarried child reaches the maximum dependent age of twenty-six (26), he or she can continue to be considered an eligible dependent only if he or she is determined by us to be a disabled dependent.

If you have an unmarried child of any age who is financially dependent upon you and medically determined to have a physical or mental impairment, which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months, that child is an eligible disabled dependent under this *agreement*.

To obtain the necessary form to verify the child's status, please contact Blue Cross Dental Customer Service. Periodically you may be asked to re-verify the child's disabled status.

When Your Coverage Begins

Your coverage will begin on the first day of the month following your eligibility date as long as we receive your enrollment form within the first thirty (30) days following your eligibility date and your premium is paid.

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
Open Enrollment is a period of time each year when you and your eligible dependents can enroll for dental coverage or make changes to your existing dental coverage. The effective date will be on the first day of your employer's *plan year*.

Special Enrollment Period
A Special Enrollment Period is a time outside the yearly Open Enrollment Period when you can sign up for dental coverage. You may enroll your eligible dependents through a Special Enrollment Period by completing an enrollment form within thirty (30) days of the following events:

- you get married.
- you have a child born to the family.
- you have a child placed for adoption with your family.

In addition, if you lose coverage from another *plan*, 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 date you lost coverage. Coverage will begin on the first day of the month following the date your coverage under the other *plan* ended. In order to be eligible, the loss of coverage must be the result of:

- legal separation or divorce;
- death of the covered policy holder;
- termination of employment or reduction in the number of hours of employment;
- the covered policy holder becomes 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.

You are also eligible for a Special Enrollment Period if you and/or your eligible dependent lose eligibility for Medicaid or a Children's Health Insurance Program (CHIP), or if you and/or your eligible dependent become eligible for premium assistance for Medicaid or a (CHIP). In order to enroll, you must complete an application within sixty (60) days following the change in eligibility. Coverage will begin on the first day of the month following our receipt of your application.

In addition, you may be eligible for a Special Enrollment Period if you apply within thirty (30) days of one of the following events:

- you or your dependent lose minimum essential coverage;
- you adequately demonstrate to us that another dental *plan* substantially violated a material provision of its contract with you;
- you make a permanent move into the service area: or
- your enrollment or non-enrollment in a qualified dental *plan* is unintentional, inadvertent, or erroneous and is the result of error, misrepresentation, or inaction by us or an agent of *HSRI* or the U.S. Department of Health and Human Services (HHS).

How to Add or Remove Coverage for Family Members

You must notify your employer if you want to add family members according to the provisions described above. To remove a family member, inform your employer in advance of the requested effective date and your employer will notify us. We cannot directly add or remove coverage for you or your family members.

When Your Coverage Ends

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

- if you leave your place of employment;
- if you decide to discontinue coverage. Inform your employer fourteen (14) days prior to the requested date of cancellation and your employer will notify us. If we do not receive your notice prior to the requested date of cancellation, you or your employer may be responsible for paying another month's premium;

- if the required premium is not paid within one month of the due date. If the required fees are not paid, the termination will be effective five (5) days after we mail you a notice of discontinuance;
- if you or a covered depended no longer qualifies as an eligible person;
- if we no longer offer this type of coverage;
- if your employer contracts with another insurer or entity to provide or administer *benefits* for the *covered dental services* provided by this *agreement*;
- if fraud is determined by us. See Rescission of Coverage section below for additional details;

When your coverage ends, you may apply for individual dental coverage from BCBSRI or through *HSRI*. You must meet the eligibility requirements and we must receive an enrollment form and required premium within sixty (60) days from the date your group coverage ended. If you do not reside in Rhode Island, you are not eligible to enroll in an individual *plan* from BCBSRI or *HSRI*. You may be able to obtain coverage through an insurance company in the state in which you reside.

Rescission of Coverage
Rescission is 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
- is due to non-payment of premiums, which can have a retroactive cancellation effect.

We may rescind your coverage if you or your dependents commit fraud. Fraud includes, but is not limited to, intentional misuse of your ID card or intentional misrepresentation of a 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 thirty (30) days in advance.

Except for non-payment, we will not contest this policy after it has been in force for a period of two (2) years from the later of the effective date of this *agreement* or the latest reinstatement date.

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 for you or your covered dependents is terminated and your coverage was made available through the group dental *plan* of an employer of twenty (20) or more employees, you may be eligible for continuation of 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 is responsible for making COBRA coverage available to you, and for complying with all of COBRA’s requirements. You should contact your employer if you have any questions about continuing coverage through COBRA.

SECTION 3: COVERED DENTAL SERVICES

This section describes *covered dental services*. This *plan* covers services only if they meet all of the following requirements:

- listed as a *covered dental service* in this section. The fact that a *dentist* has prescribed or recommended a service, or that it is the only available treatment for an illness or injury does not mean it is a *covered dental service* under this *plan*.
- *dentally necessary* services or *medically necessary* orthodontics, consistent with our dental policies and related guidelines at the time the services are provided.
- not listed in Exclusions section.
- received while a *member* is enrolled in the *plan*.
- consistent with applicable state or federal law.

We review *dental necessity* in accordance with our dental policies and related guidelines. Our dental policies can be found on our website.

This *plan* only covers dental services that are *dentally necessary.* To help ensure that you and your *dentist* understand your *benefits* before the service is rendered, we recommend that you obtain a *predetermination.* A *predetermination* will provide your *dentist* with a coverage estimate for the services requested. We recommend that you or your *dentist* request a *predetermination* for the *covered dental services* in the Summary of *Benefits* marked with a (*).

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

Multi-stage Procedures

This *plan* pays for a *covered dental service* that is a *multi-stage procedure* based on the *completion date* of the *multi-stage procedure*. Examples of *multi-stage procedures* include, but are not limited to, crowns, certain onlays, bridges, dentures, and partial dentures.

This *plan* covers *multi-stage procedures* with a *start date* before the effective date of this *plan* only if:

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

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

Note: *Members* are entitled to only those *benefits* listed in the Summary of Benefits. Please be sure to review the information in the Summary of Benefits, as well as in the Exclusions section, in reference to the information about *covered dental services* below.

Basic Preventive and Diagnostic Services

Oral Evaluations
This *plan* covers one (1) initial oral examination, a periodic oral examination, or an emergency oral examination, (which includes diagnosis and charting), when performed by a general *dentist* (which includes pedodontists and prosthodontists) per calendar year.

Cleanings (Prophylaxis)
This *plan* covers two (2) cleanings per calendar year**.** Besides these two (2) cleanings provided per *plan year*, *members* who are pregnant are also provided one (1) additional cleaning during their pregnancy.

X-rays
This *plan* covers one (1) set of bitewing x-rays per calendar year. Single x-rays are covered as needed. One (1) full mouth set of intraoral (including bitewings) or panorex x-rays is covered every thirty-six (36) months.

Fluoride Treatments
This *plan* covers one (1) fluoride treatment per calendar year for *members* under age 19.

Sealants
This *plan* covers one (1) sealant in a twenty-four (24) month period on permanent molars for *members* under age eighteen (18).

Denture Repairs, Relines, and Rebasing
This *plan* covers full or partial denture repairs, relines, and rebasing once per thirty-six (36) month period per arch (upper and lower).

Space Maintainers
This *plan* covers space maintainers that are not made of cast precious metals.

Palliative Treatment
This *plan* covers two (2) visits per *plan year* for minor treatment to relieve acute dental pain when the two visits are not performed on the same day by the same *dentist*.

Minor Restorative Services

Fillings
This *plan* covers amalgam fillings (silver fillings) and composite fillings (white fillings) for all teeth.

Recementations
This *plan* covers the recementation of crowns and bridges once per tooth per thirty-six (36) month period.

Simple Extractions
This *plan* covers the simple extraction of an erupted tooth that does not require a surgical procedure.

Therapeutic Pulpotomies
This *plan* covers therapeutic pulpotomy for primary teeth.

Biopsies
This *plan* covers biopsies and examinations of hard or soft oral tissue.

Root Canal Therapy
This *plan* covers root canal therapy for all permanent teeth, excluding final restoration.

Non-surgical Periodontal Services and Periodontal Maintenance
This *plan* covers periodontal maintenance, following documented periodontal surgery, two (2) times per calendar year if at least three (3) months have passed since the completion of active periodontal surgery.

This *plan* covers periodontal scaling and root planing once (1) per thirty-six (36) month period, per quadrant.

Enhanced *benefits* for these services may be available for *members* diagnosed with diabetes and/or coronary artery disease. Please see Total Health Solutions and Summary of Dental *Benefits* for additional information.

Major Restorative Services

Crowns and Onlays
This *plan* covers single tooth crowns and onlays that are not part of a bridge to restore natural teeth. This *plan* covers replacements once in a sixty (60) month period if the existing crown or onlay is not serviceable and cannot be repaired.

Oral Surgery Services
This *plan* covers surgical extractions and other oral surgical procedures that are *dentally necessary* and meet our dental policies and related guidelines when the oral surgery is not covered under your medical insurance *plan*.

General Anesthesia or Intravenous Sedation (IV)
This *plan* covers in a dental office general anesthesia and intravenous sedation when rendered in conjunction with certain covered oral surgical procedures.

Surgical Periodontal Services
This *plan* covers surgical periodontal services and procedures for the treatment of tissues supporting the teeth.

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

Prosthodontics

Bridges and Dentures

This *plan* covers services for fixed bridges and full or partial dentures. This *plan* covers replacements once in a sixty (60) month period if the existing fixed bridge or full or partial denture is not serviceable and cannot be repaired.

This *plan* covers crowns over implants as a prosthodontic service.

Implants

This *plan* covers a single tooth implant as a prosthodontic service when placed as an alternative treatment to a conventional 3-unit bridge and the single tooth implant replaces one missing tooth that has *sound natural teeth* or sound dental implant(s) on both sides of the missing tooth site.

Orthodontics

Orthodontic Services

This *plan* covers orthodontics and related services up to the *lifetime maximum benefit*. See the Summary of Dental Benefits.

SECTION 4: EXCLUSIONS

This section lists the services or categories of services that are not covered (excluded) under this *plan*. We will not cover services listed in this section even if they are prescribed or recommended by your *dentist*. We will not cover dental services that are not *dentally necessary.* This is true whether or not they are listed in this section.

Dental Services Not Covered

- Dental services performed that do not comply with the timeframes and limitations in our dental policies and related guidelines.
- New dental procedures or services that are not included in our dental policies and related guidelines.
- Dental services rendered at a hospital by interns, residents, or staff *dentists*.
- Limited scope oral examinations when performed by a *dentist* who limits his or her practice to a specialty branch of dentistry. Examples include oral examinations for periodontics, orthodontics, endodontics, and oral surgery.
- Orthodontic or prosthetic appliances and space maintainers that are misplaced, lost, or stolen.
- Services of an anesthesiologist.
- General anesthesia and intravenous sedation, unless rendered in conjunction with covered oral surgical procedures.
- Cosmetic procedures that 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.
- Dental implants except for the limited circumstance described in Section 3 for a single tooth implant.
- Implant support prosthesis or other implant related services.
- Injectable or prescription drugs.
- *Experimental* or *investigational* procedures or services. *Experimental* or *investigational* means any dental procedure that has progressed to limited human application, but has not been recognized as clinically proven and effective.
- Services completed prior to the effective date of this *plan.*
- Occlusal guards to treat temporomandibular joint dysfunction (TMJ), sleep apnea, or snoring.
- Occlusal guards when used as an athletic mouth guard or orthodontic retainer.
- Services for or related to the treatment of TMJ.
- Appliances or restorations necessary to increase vertical dimensions or to restore the occlusion.
- Travel expenses or other related expenses that may be incurred by a *dentist* providing services.

Excluded Dentists

- Services performed by a *dentist* who has been excluded or debarred from participation in federal programs, such as Medicare and Medicaid. To determine whether a *dentist* has been excluded from a federal program, visit the U.S. Department of Human Services Office of Inspector General website (https://exclusions.oig.hhs.gov/) or the Excluded Parties List System website maintained by the U.S. General Services Administration (https://www.sam.gov/).
- Services provided by *dentists* or other providers who are not legally qualified or licensed, according to relevant sections of Rhode Island Law or other governing bodies, or who have not met our credentialing requirements.
- Services provided by naturopaths, homeopaths, or Christian Science practitioners.

Dental Services Available or Provided from Other Sources

- Services 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 or supplies for military-related conditions, such as war, or any military action, which takes place after your coverage becomes effective.
- Services received in a facility mainly meant to care for students, faculty, or employees of a college or other institution of learning.
- *Covered dental services* provided to you when there is no *charge* to you or there would have been no *charge* to you absent this dental *plan*.
- Services if another entity or agency is responsible under state or federal laws, which are provided for the health of schoolchildren or children with disabilities. See Title 16, Chapters 21, 24, 25, and 26 of the R.I. General Laws. See also applicable regulations about the health of schoolchildren and the special education of children with disabilities or similar rules set forth by federal law or state law of applicable jurisdiction.
- Services and supplies which are required under the laws of a state, other than Rhode Island, and are not provided under this dental *plan*.

All Other Exclusions

- Services not approved by the FDA or other governing body.
- Services we have not reviewed or we have not determined are eligible for coverage.
- Services obtained through fraud or intentional misrepresentation.
- Administrative service *charges* for:
  - missed appointments;
  - completion of *claim* forms;
  - additional fees, sometimes referred to as access fees, associated with concierge, boutique, or retainer practices; and
  - any other administrative *charges*.
- Continuation of a *covered dental service* or *benefit* as a result of a clerical error.
- Educational classes.
- Exams and services provided when the services are needed for or related to employment, education, marriage, adoption, insurance purposes, court order, or

when required by similar third parties when the *benefit limit* for the exam or service has been met.

- Telephone consultations, telephone services, or medication monitoring by phone.
- Employment related injuries for dental services when provided 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.
- Research studies.
- Services provided by relatives whether by blood, marriage, or adoption, or other members of your household.

SECTION 5: REQUESTS FOR AUTHORIZATION, DENIALS, COMPLAINTS, AND APPEALS

Requests for Authorization

We evaluate the *dental necessity* for select *covered dental services* using clinical criteria to facilitate clinically appropriate, cost-effective management of your care. This process is called *utilization review*, and it can occur in the following situations:

- When you or your *dentist* request authorization for a service before receiving it *(predetermination*).
- When you or your *dentist* request authorization for a service that is already initiated or ongoing (concurrent authorization).
- When you or your *dentist* request authorization for a service you have already received (retrospective authorization).

The determination of whether a service is *dentally necessary* is solely for the purpose of *claims* payment and the administration of health *benefits* under this *plan*. It is not an exercise of professional dental judgment. BCBSRI does not act as a *dentist*. We do not furnish dental care. You are not prohibited from having a treatment for which reimbursement was not authorized. Nothing here will change or affect your relationship with your *dentist(s)*.

We may contract with an organization to conduct *utilization review* on our behalf. If another company does *utilization review* on our behalf, the company will act as an independent contractor and is not a partner, agent, or employee of BCBSRI.

Predetermination

Predetermination is the process by which we determine whether a dental service is a covered *benefit* under your *plan* and is *dentally necessary* before you receive the service.

To obtain a *predetermination*, you or your *dentist* may send us your dental treatment plan in advance of the dental service being performed. We will review the treatment plan and then let you and your *dentist* know if the service will be covered under your *plan*. A *predetermination* is an estimate of the *benefits* available at the time of the *predetermination* request. A *predetermination* is not a guarantee of payment, as your *benefit limits* and eligibility status may change before the service is performed.

Both n*etwork dentists* and *non-network dentists* may obtain *predetermination* for *covered dental services*. If your *dentist* is a *non-network dentist*, you may request a *predetermination* for *covered dental services* by calling Blue Cross Dental Customer Service. See Section 9 for contact information.

You may request a *predetermination* for any *covered dental service*, but dental services for which *predetermination* is recommended are indicated in the Summary of *Benefits* with a (*).

A notification of the *predetermination* will be provided prior to the date of service but no later than fifteen (15) calendar days from receipt of the request.

Obtaining *predetermination* is not a requirement in order for *covered dental services* to be covered.

When we determine that the services are not *dentally necessary* or not a *benefit* under your *plan*, that service is not covered. You will be responsible for the cost of the services. You have the right to appeal our determination or to take legal action as described in this section.

Please note: You do not need *predetermination* for *emergency* services.

Expedited Predetermination
You may request an expedited *predetermination* review in an *emergency*. We will respond to you with a determination within seventy-two (72) hours following receipt of the request.

Concurrent Authorization
We review requests for concurrent authorization when you need an extension of an authorized course of treatment beyond the period of time or number of treatments already approved. If we deny your request, we will notify your *dentist* before the end of the treatment period and will let you know within one business day of making the determination. You have the right to appeal our determination or to take legal action as described in this section.

Retrospective Authorization
We review requests for retrospective authorization when services were provided before authorization was obtained. A notification of the retrospective determination will be provided within thirty (30) calendar days from receipt of the request. You have the right to appeal our determination or to take legal action as described in this section.

Denials

A *claim* denial, also known as an adverse *benefit* determination, is any of the following:
- a full or partial denial of a *benefit*;
- a reduction of a *benefit*;
- a termination of a *benefit*;
- a failure to provide or make a full or partial payment for a *benefit*; and
- a rescission of coverage, even if there is no adverse effect on any *benefit*.

If we deny payment for a service we determine not *dentally necessary,* a determination letter will be provided with the following information:
- reason for the denial;
- clinical criteria used to make the determination as well as how to obtain a copy of the clinical criteria; and
- instructions for filing an appeal**.**

If you have questions, please contact Blue Cross Dental Customer Service. See Section 9 for contact information. You may also contact the Office of the Health Insurance Commissioner's Consumer Resource Program (RIREACH) at 1-855-747-3224 about questions or concerns you may have.

Complaints

A complaint is an expression of dissatisfaction with any aspect of our operation or the quality of care you received from a *dentist*. A complaint is not an appeal. For information about submitting an appeal, please see the Appeals section below.

We encourage you to discuss any concerns or issues 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 if they are raised when they occur. However, if you remain dissatisfied or prefer not to take up the issue with your *dentist*, you can call Blue Cross Dental Customer Service for further assistance. You may also call Blue Cross Dental Customer Service if you are dissatisfied with any aspect of our operation.

If the concern or issue is not resolved to your satisfaction, you may file a verbal or written complaint with Blue cross Dental Customer Service.

We will acknowledge receipt of your complaint or administrative appeal within ten (10) business days. We will conduct a thorough review of your complaint and respond within thirty (30) calendar days of the date it was received. The determination letter will provide you with the rationale for our response as well as information on any possible next steps available to you.

When filing a complaint, please provide the following information:

- your name, address, *member* ID number;
- the date of the incident or service;
- summary of the issue;
- any previous contact with BCBSRI concerning the issue;
- a brief description of the relief or solution you are seeking; and
- additional information such as *claims* or any other documentation that you would like us to review.

Please send all information to the address listed on the Contact Information section.

Appeals

If you experience a problem relating to a *predetermination,* an authorization review, a *benefit* denial, or other aspect of this *plan*, we have internal and external procedures to help you resolve your issue.

The following sections detail the processes and procedures for filing:

- Administrative Appeals;
- Dental Appeals (including expedited appeals); and
- External Appeals.

When filing an appeal, please provide the same information listed in the Complaints section above.

Administrative Appeals
An administrative appeal is a request for us to reconsider a full or partial denial of payment for *covered dental services* for the following reasons:

- the services were excluded from coverage;
- we determined that you were not eligible for coverage;
- you or your *dentist* did not follow BCBSRI's requirements; or
- a limitation on an otherwise covered *benefit* exists.

You are not required to file a complaint (as described above), before filing an administrative appeal. If you call Blue Cross Dental Customer Service, a Customer Service Representative will try to resolve your concern. If the issue is not resolved to your satisfaction, you may file a verbal or written administrative appeal.

If you request an administrative appeal, you must do so within one hundred eighty (180) days of receiving a denial of payment for *covered dental services*.

We will conduct a thorough review of your administrative appeal and respond within fifteen (15) calendar days of the date it was received. The letter will provide you with information regarding our determination.

Dental Request for Reconsideration Appeals
A dental reconsideration or appeal is a request for us to reconsider a full or partial denial of payment for *covered dental services* because we determined:

- the dental service was not *dentally necessary* or appropriate;
- the service was *experimental or investigational*.

You may request an expedited appeal when the circumstances are an *emergency.*

How to File a Dental Request for Reconsideration
You or your *dentist* may file a written or verbal dental request for reconsideration with us. The dental request for reconsideration must be submitted to us within one hundred and eighty (180) calendar days of the initial determination letter. See Section 9 for contact information.

If someone other than your *dentist* is filing a dental appeal on your behalf, you must provide us with a signed notice, authorizing the individual to represent you in this matter.

You will receive written notification of our determination within fifteen (15) calendar days, from the receipt of your request for reconsideration.

How to File an Appeal of a Dental Reconsideration
You may request an appeal if our denial was upheld during the initial dental reconsideration. Your appeal will be reviewed by a *dentist* in the same or similar specialty as your treating *dentist*. You must submit your request for an appeal within forty-five (45) calendar days of receiving of the reconsideration denial letter.

You will receive written notification of our appeal determination within fifteen (15) calendar days from the receipt of your request for an appeal.

At any time during the review process, you may supply additional information to us. You may also request copies of information relevant to your request (free of charge) by contacting us.

How to File an Expedited Appeal
Your appeal may require immediate action if a delay in treatment could seriously jeopardize your health or your ability to regain maximum function, or would cause you severe pain.

To request an expedited appeal of a denial related to services that have not yet been rendered (a prospective review), you or your *dentist* should call us. See Section 9 for contact information.

You will be notified of our decision no later than seventy-two (72) hours after our receipt of the request.

You may not request an expedited review of *covered dental services* already received.

How to Request an External Appeal
If you remain dissatisfied with our dental appeal determination, you may request an external review by an outside review agency. Your *claim* does not have to meet a minimum dollar threshold in order for you to be able to request an external appeal.

To request an external appeal, submit a written request to us within four (4) months of your receipt of the dental appeal denial letter. We will forward your request to the outside review agency.

Upon receipt of the information, the outside review agency will notify you of its determination within ten (10) calendar days, unless it is an urgent appeal, and then you will be notified within seventy-two (72) hours.

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

Filing an external appeal is voluntary. You may choose to participate in this level of appeal or you may file suit in an appropriate court of law (see Legal Action, below).

Once a *member* or *dentist* receives a decision at one of the several levels of appeals noted above, (reconsideration, appeal, or external), the *member* or *dentist* may not ask for an appeal at the same level again, unless additional information that could affect such decisions can be provided.

Legal Action

If you are dissatisfied with the determination of 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.

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*.

For *members* covered by a group (employer sponsored) dental *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 appeals available under the *plan*. That means, for both dental and administrative appeals, federal law requires that you pursue a final decision from the *plan*, prior to filing suit under section 502(a) of ERISA. For a dental appeal, that final decision is the determination of the appeal. 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.

SECTION 6: CLAIM FILING AND DENTIST PAYMENTS

This section provides information regarding how a *member* may file a *claim* for a *covered dental service* and how we pay *dentists* for a *covered dental service*.

How to File a Claim

Network dentists file *claims* on your behalf.

Non-network dentists may or may not file *claims* on your behalf. If a *non-network dentist* does not file a *claim* on your behalf, you will need to file it yourself. To file a *claim*, please send us the *dentist's* itemized bill, and include the following information:

- your name;
- your *member* ID 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 send your *claim* to the claim filing mailing address listed in the Contact Information section.

Claims must be filed within one calendar year of the date you receive a *covered dental service*. *Claims* submitted after this deadline are not eligible for reimbursement. This timeframe does not apply if you are legally incapacitated.

How Network Dentists Are Paid

We pay *network dentists* directly for *covered dental services*. *Network dentists* agree not to bill, *charge*, collect a deposit from, or seek reimbursement from you for a *covered dental service*, except for your share under the *plan.*

When you see a *network dentist*, you are responsible for a share of the cost of *covered dental services*. Your share includes the *deductible*, if one applies, and the *coinsurance*, as listed in the Summary of *Benefits*. In addition, reimbursement for *covered dental services* is always subject to your *annual maximum benefit*.

Your *dentist* may request these payments at the time of service or may bill you after the service. If you do not pay your *dentist*, the *dentist* may decline to provide current or future services or may pursue payment from you, such as beginning collection proceedings.

How Non-network Dentists Are Paid

If you receive care from a *non-network dentist*, including *emergency* or urgent care, you are responsible for paying all *charges* for the services you received.

You may submit a *claim* for reimbursement of the payments you made.

When you receive *covered dental services* from a *non-network dentist* located in Rhode Island or Massachusetts, we reimburse you or the *non-network dentist* up to the lesser of our *allowance* or the *charge.* The *allowance* for *covered dental services* is based on the maximum amount we would pay to a *network dentist* located in Rhode Island or Massachusetts. In some instances, you may be responsible to pay the *non-network dentist's* full *charge* at the time of service. You are responsible for the *deductible*, if one applies, and the *coinsurance*. In addition, reimbursement for *covered dental services* is always subject to your *annual maximum benefit*. For *emergency* or urgent care services, the amount you pay is the same as a *network dentist*.

When you receive *covered dental services* from a *non-network dentist* located outside of Rhode Island or Massachusetts, we reimburse you or the *non-network dentist* up to the lesser of our *allowance* or the *charge.* The *allowance* for *covered dental services* is based on a schedule of fees for *covered dental services* provided in that geographic area. In some instances, you may be responsible to pay the *non-network dentist's* full *charge* at the time of service. You are responsible for the *deductible*, if one applies, and the *coinsurance*. In addition, reimbursement for *covered dental services* is always subject to your *annual maximum benefit*. For *emergency* or urgent care services, the amount you pay is the same as a *network dentist*.

You are liable for the difference between the amount that the *non-network dentist* bills and the payment we make for *covered dental services*. Our payments to you or the *dentist* fulfill our responsibility under this *plan*.

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.

SECTION 7: COORDINATION OF BENEFITS AND SUBROGATION

Introduction

This Coordination of *Benefits* (COB) provision applies when you or your covered dependents have dental coverage under more than one *plan*.

This *plan* follows the COB rules of payment issued by the Rhode Island Office of the Health Insurance Commissioner (OHIC) in Regulation 230-RICR-20-30-2, and the National Association of Insurance Commissioners (NAIC). From time to time these rules may change before a revised *agreement* can be provided. The most current COB regulations in effect at the time of coordination are used to determine the *benefits* available to you.

When this provision applies, the order of *benefit* determination rules described below will determine whether we pay *benefits* before or after the *benefits* of another *plan*.

Note: For coverage to be provided under this *plan,* whether this *plan* is *primary* or *secondary*, services must be *dentally necessary* or *medically necessary* (orthodontic services). Dental services paid by other *plans* will be considered when determining *benefits* under this *plan*. When this *plan* is *secondary*, dental services that exceed the *benefit limits* available under this *plan* are not covered.

Definitions

The following definitions apply to this section. For additional definitions, see Section 8. When the defined term is used, it will be *italicized* in this section.

ALLOWABLE EXPENSE means a 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 *plan* is in force.

When a *plan* provides dental coverage in the form of services, the reasonable cash value of each service is considered as both an *allowable expense* and a *benefit* paid.

PLAN means any of the following that provides *benefits* or services for dental care or treatment. If separate contracts are used to provide coordinated coverage for *members* of a group, the separate contracts are considered parts of the same *plan* and there is no COB among those separate contracts.

1. *Plan* includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel *plans* or other forms of group or group-type coverage (whether insured or uninsured); dental care components of long-term care contracts, such as skilled nursing care; dental *benefits* under group or individual automobile contracts; and Medicare or any other federal governmental *plan*, as permitted by law.

2. *Plan* does not include: *hospital* indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited *benefit* health coverage, as defined by state law; school accident type coverage; university student health plans; *benefits* for non-dental components of long-term care policies; Medicare supplement policies; Medicaid policies; or
coverage under other federal governmental *plans*, unless permitted by law.

Each contract for coverage under numbers 1 or 2 above is a separate *plan*. If a *plan* has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate *plan*.

***PRIMARY PLAN* (*PRIMARY*)** means a *plan* whose *benefits* for a person's dental coverage must be determined without taking the existence of any other *plan* into consideration.

***SECONDARY PLAN* (*SECONDARY*)** means a *plan* that is not a *primary plan*.

When You Have More Than One Plan with BCBSRI

If you are covered under more than one *plan* with us, you are entitled to covered *benefits* under both *plans*. If one *plan* has a *benefit* that the other(s) does not, you are entitled to coverage under the *plan* that has the *benefit*. The total payments you receive will never be more than the total *allowable expense* for the services you receive.

When You Are Covered by More Than One Insurer

A dental coverage *plan* is considered the *primary plan* and its *benefits* will be paid first if:

- the *plan* does not use similar COB rules to determine coverage; or
- the *plan* does not have a COB provision; or
- the *plan* has similar the COB rules and is determined to be *primary* under the order of *benefit* determination rules described below.

Benefits under another *plan* include all *benefits* that would be paid if *claims* had been initially submitted under that *plan*.

The following factors are used to determine which *plan* is *primary* and which *plan* is *secondary:*

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

These factors make up the order of *benefit* determination rules, described in greater detail below:

(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* that 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 *plan* is a student, and has additional coverage through a student *plan*, then the *benefits* from the student *plan* will be determined before the *benefits* under this *plan*.

(2) Dependent Child

If dependent children are covered under separate *plans* of more than one person, whether a parent or guardian, *benefits* for the child will be determined in the following order:

- the *benefits* of the *plan* covering the parent born earlier in the year will be determined before those of the parent whose birthday (month and day only) falls later in the year;
- if both parents have the same birthday, the *benefits* of the *plan* that covered the parent longer are determined before those of the *plan* which covered the other parent for a shorter period of time;
- 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 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*.
- both parents share joint custody, without stating that one of the parents is responsible for the dental expenses of the child, the *plans* covering the child will follow the order of *benefit* determination rules outlined above.

(4) Active/Inactive Employee

If you are covered under another *plan* as an active employee, your *benefits* and those of your dependents under that *plan* will be determined before *benefits* under this *plan*. The *plan* covering the active employee and dependents will be the *primary plan*. The *plan* covering that same employee as inactive (including those who are retired or have been laid off) will be the *secondary plan* for that employee and dependents.

(5) COBRA/Rhode Island Extended Benefits (RIEB)

If this *plan* is provided to you under COBRA or RIEB, and you are covered under another *plan* as an employee, retiree, or dependent of an employee or retiree, the *plan* covering you as an employee, retiree or dependent of an employee or retiree will be *primary* and the COBRA or RIEB *plan* will be the *secondary plan*.

(6) Longer/Shorter Length of Coverage

If none of the above rules determine the order of *benefits*, the *benefits* of the *plan* that covered a *member* or *subscriber* longer are determined before those of the *plan* that covered that person for the shorter term.

How We Calculate Benefits Under These Rules

When this *plan* is *secondary*, it may reduce its *benefits* so that the total *benefits* paid or provided by all *plans* are not more than the total *allowable expenses*. In determining the amount to be paid for any *claim*, the *secondary plan* will calculate the *benefits* it would have paid in the absence of other dental coverage and apply that calculated amount to any *allowable expense* under its *plan* that is unpaid by the *primary plan*. The *secondary plan* may then reduce its payment by the amount so that, when combined with the amount paid by the *primary plan*, the total *benefits* paid or provided by all *plans* for the *claim* do not exceed the total *allowable expense* for that *claim*. In addition, the *secondary plan* shall credit to its *plan deductible* any amounts it would have credited to its *deductible* in the absence of other dental coverage.

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 *plan* and we will not have to pay those amounts again.

If we make 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 paid, provide information and assistance, or do whatever is necessary to aid in the recovery of this excess amount. The amount of payments made includes the reasonable cash value of any *benefits* provided in the form of services.

Our Right of Subrogation and/or Reimbursement

Subrogation

You may have a legal right to recover some or all of the costs of your dental care from someone else called a third party. Third party means any person or company that is, or could be, responsible for the costs of injuries or illness to you or any other dependent. This includes such costs to you or any other dependent covered under this *plan*.

If we pay for costs a third party is responsible for, we reserve the right to recover up to the full amount we paid. Our rights of recovery apply to any payment made to you or due to you from any source. This includes, but is not limited to:

- payment made or due by a third party;
- payments made or due by any insurance company on behalf of the third party;
- any payments or rewards made or due under an uninsured or underinsured motorist coverage policy;
- any disability award or settlement payment made or due;
- dental coverage payments made or due under any automobile policy;
- premises or homeowners' dental coverage payments made or due;
- premises or homeowners' insurance coverage; and
- any other payments made or due from a source intended to compensate you for third party injuries.

We have the right to recover those payments made for *covered dental services*. We can do this with or without your consent. Our right has priority, except as otherwise provided by law. We can recover against the total amount of any recovery, regardless of whether all or part of the recovery is for dental expenses or the recovery is less than the amount needed to reimburse you fully for the illness or injury.

We may contract with a third party or subrogation agent to administer subrogation recoveries.

Reimbursement
In addition to the subrogation rights described above, we also have reimbursement rights. If you recover money by lawsuit, settlement, or otherwise, we may seek reimbursement from you for *covered dental services* for which we paid or will pay. Our reimbursement right applies when you received payment from a third party for *covered dental services* we provided under this *plan*, as described in the subrogation section above.

We can seek from you reimbursement up to the amount of any payment made to you, whether

- all or part of the payment to you was designated, allocated, or characterized as payment for dental expenses; or
- the payment is for an amount less than that necessary to compensate you fully for the illness or injury.

We may offset future payments under this *plan* until we have been paid an amount equal to what you were paid by a third party for the cost of the *covered dental services* that we paid or will pay. If we pay legal fees to recover money from you, we can recover those costs from you as well. The amount you must pay us cannot be reduced by any legal costs you have paid.

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, at that time, so we can respond in court.

Member Cooperation
You further agree:

- to notify us promptly and in writing when notice is given to any third party or representative of a third party of the intention to investigate or pursue a *claim* to recover damages or obtain compensation;
- to cooperate with us and provide us with requested information;
- to do whatever is necessary to secure our rights of subrogation and reimbursement under this *plan*;
- to assign us any *benefits* you may be entitled to receive from a third party. Your assignment is up to the cost of the *covered dental services*;
- to give us a first priority lien on any recovery, settlement, or judgment or other source of compensation which may be had by any third party. You agree to do this to the extent of the full cost of all *covered dental services* associated with third party responsibility;
- to do nothing to prejudice our rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of the *covered dental services* provided by this *plan*;
- to serve as a constructive trustee for the benefit of this *plan* over any settlement or recovery funds received as a result of third party responsibility;

- that we may recover the full cost of the *covered dental services* provided by this *plan* without regard to any *claim* of fault on your party, whether by comparative negligence or otherwise;
- that no court costs or attorney fees may be deducted from our recovery;
- that we are not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by you to pursue your *claim* or lawsuit against any third party; and
- that in the event you or your representative fails to cooperate with us, you shall be responsible for all costs associated with *covered dental services* provided by this *plan*, in addition to costs and attorney fees incurred by this *plan* in obtaining repayment.

SECTION 8: GLOSSARY

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

***AGREEMENT* (*SUBSCRIBER AGREEMENT*)** means this document. It is a legal contract between you and BCBSRI.

ALLOWANCE is the amount a *network dentist* has agreed to accept for a *covered dental service*.

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 *copayments*, *deductibles*, and the difference between the *benefit limit* and our *allowance*, if any.

When you receive *covered dental services* from a *non-network dentist located in Rhode Island or Massachusetts,* the *allowance* for covered services is based on the maximum amount we would pay to a *network dentist located in Rhode Island or Massachusetts.* You are responsible for a *non-network dentist's* full *charge*. In some instances, you may be responsible to pay the *non-network dentist's* full *charge at the time of service*. Any required *coinsurance* or *deductibles* will be applied to this *allowance* before we reimburse you.

When you receive *covered dental services* from a *non-network dentist outside of Rhode Island or Massachusetts,* the *allowance* for covered services 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*. In some instances, you may be responsible to pay the *non-network dentist's* full *charge at the time of service*. 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 this *plan* will pay for *covered dental services* per *member* per calendar year.

BENEFIT LIMIT means the total *benefit* allowed under this *plan* for a *covered dental service*. The *benefit limit* may apply to the amount we pay, the duration, or the number of visits for a *covered dental service*.

BENEFITS means any treatment or service that you receive reimbursement for under a *plan*.

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.

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

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

COVERED DENTAL SERVICES means any service, treatment, or procedure that we have reviewed and determined is eligible for reimbursement under this *plan*.

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

DENTALLY NECESSARY* (*DENTAL NECESSITY) means that the dental services provided by a *dentist* to identify or treat your dental or oral health condition, upon review by BCBSRI, 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 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 that 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. Please see Appeals in Section 5 for details.

We may review *dental necessity* on a case-by-case basis. We determine *dental necessity* solely for purposes of *claims* payment based on our dental policies and related guidelines under this *plan*.

DENTIST means a person licensed and registered to practice dentistry.

EMERGENCY means a dental condition manifesting itself by acute symptoms. The acute symptoms are severe enough (including severe pain) that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that without immediate dental attention serious jeopardy to the health of a person (or, with respect to a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions, or serious dysfunction of any bodily organ or part could result.

EXPERIMENTAL OR INVESTIGATIONAL means any dental service that has progressed to limited human application, but has not been recognized as proven and effective in clinical dentistry.

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

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

***NETWORK DENTIST* (*NETWORK*)** is a *dentist* that has entered into an agreement with us or 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 or does not participate in the Dental Coast to Coast Network.

PLAN means any health insurance *benefit* package provided by the *plan* sponsor. The *plan* sponsor is RI Laborers Health Fund.

PLAN YEAR means a twelve (12) month period, determined by your employer. *Benefit limits*, *deductibles* (if any), your *maximum out-of-pocket expenses,* and your *annual maximum benefit* are calculated under this *plan* based on the *plan year.*

PREDETERMINATION is a procedure whereby you or your *dentist* sends us your treatment plan before treatment is rendered and we review to determine if a proposed treatment is covered under your *plan*. A *predetermination* is an estimate, not a guarantee of payment, and is based on your eligibility status and *benefits* at the time of the request. It is subject to change.

SOUND NATURAL TEETH means teeth that:

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

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

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

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

WE*, *US*,** and ***OUR means Blue Cross & Blue Shield of Rhode Island. WE, US, or OUR will have the same meaning whether *italicized* or not.

YOU and ***YOUR*** means the *subscriber* or *member* enrolled for coverage under this *agreement*. You and your will have the same meaning whether *italicized* or not.

SECTION 9: CONTACT INFORMATION

Blue Cross Dental Customer Service
Business hours are Monday thru Friday 8 a.m. to 8 p.m.
In state:
401-453-4700;
Out of state:
1-800-831-2400;
Hearing impaired: 711

Website
www.bcbsri.com

Claim Filing Mailing Address
Blue Cross & Blue Shield of Rhode Island
Dental Claims Administrator
P.O. Box 69427
Harrisburg, PA 17106-9427

Appeal Submission Mailing Address
Blue Cross & Blue Shield of Rhode Island
Dental Customer Service – Appeals
P.O. Box 69420
Harrisburg, PA 17106-9420

Your Blue Store
You may also visit one of our retail walk-in service centers. Please check our website for specific locations and business hours.

Emergency Care
If you need *emergency* care, call 911 or go to the nearest hospital *emergency* room. If you are traveling outside our service area and need urgent care, call the Blue Cross Dental Customer Service number above. You may also visit our website and use the "Find A Doctor" feature to find a *dentist*.

Fraud, Waste and Abuse
If you have concerns about being billed for services you never received, or that your insurance information has been stolen or used by someone else, you may report potential health care fraud, waste or abuse to our Special Investigations Unit by using our confidential anti-fraud hotline at 1-800-830-1444 or by email at SIU@bcbsri.org. You may also send an anonymous letter to us at:

Blue Cross & Blue Shield of Rhode Island
Special Investigations Unit
500 Exchange Street
Providence RI, 02903

SECTION 10: NOTICES AND DISCLOSURES

Genetic Information

This *plan* 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 *plan* or at any time for underwriting purposes.

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*;
- coordination of dental coverage; and
- health oversight activities.

Our release of information about you is regulated by law. Please see the Rhode Island Confidentiality of HealthCare Communications and Information Act, R.I. Gen. Laws §§ 5-37.3-1 et seq. the Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act, and implementing regulations, 45 C.F.R. §§ 160.101 et seq. (collectively “HIPAA”), the Gramm-Leach-Bliley Financial Modernization Act, 15 U.S.C. §§ 6801-6908, the Rhode Island Office of the Health Insurance Commissioner (OHIC) Regulation 100.

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Nondiscrimination and Language Assistance

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

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

If you need these services, contact us at 800-831-2400.

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

English: If you, or someone you're helping, has questions about Blue Cross & Blue Shield of Rhode Island, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-831-2400.

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross & Blue Shield of Rhode Island, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-831-2400.

Portuguese: Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Blue Cross & Blue Shield of Rhode Island, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-800-831-2400.

Chinese: 如果您，或是您正在協助的對象，有關於插入項目的名稱 Blue Cross & Blue Shield of Rhode Island 方面 的問題，您有權利免費以您的母語得到幫助和訊息. 洽詢一位翻譯員，請撥電話 [在此插入數字 1-800-831-2400.

French Creole: Si oumenm oswa yon moun w ap ede gen kesyon konsènan Blue Cross & Blue Shield of Rhode Island, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-800-831-2400.

Cambodian-Mon-Khmer: ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងតែជួយ មានសំណួរអំពី Blue Cross & Blue Shield of Rhode Island ទេ, អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មាន នៅក្នុងភាសា របស់អ្នក ដោយមិនអស់ប្រាក់ ។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូម 1-800-831-2400.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross & Blue Shield of Rhode Island, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-800-831-2400.

Italian: Se tu o qualcuno che stai aiutando avete domande su Blue Cross & Blue Shield of Rhode Island, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-800-831-2400.

Laotian: ຖ້າທ່ານ, ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ມີຄຳຖາມກ່ຽວກັບ Blue Cross & Blue Shield of Rhode Island, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1-800-831-2400.

Arabic: إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue Cross & Blue Shield of Rhode Island، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.
للتحدث مع مترجم اتصل بـ 1-800-831-2400.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross & Blue Shield of Rhode Island, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-831-2400.

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross & Blue Shield of Rhode Island, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-800-831-2400.

Kru: I bale we, tole mut u ye hola, a gwee mbarga inyu Blue Cross & Blue Shield of Rhode Island, U gwee Kunde I kosna mahola ni biniiguene I hop wong nni nsaa wogui wo. I Nyu ipot ni mut a nla koblene we hop, sebel 1-800-831-2400.

Ibo: Ọ bụrụ gị, ma o bụ onye I na eyere-aka, nwere ajụjụ gbasara Blue Cross & Blue Shield of Rhode Island, I nwere ohere iwenta nye maka na ọmụma na asụsụ gị na akwu gị ụgwọ. I chọrọ I kwụrụ onye-ntapịa okwu, kpọ 1-800-831-2400.

Yoruba: Bí ìwọ, tàbí ẹnikẹni tí o n ranlọwọ, bá ní ibeere nípa Blue Cross & Blue Shield of Rhode Island, o ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ongbufọ kan sọrọ, pè sórí 1-800-831-2400.

Polish: Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Blue Cross & Blue Shield of Rhode Island, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-800-831-2400.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이Blue Cross & Blue Shield of Rhode Island 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-800-831-2400 로 전화하십시오.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross & Blue Shield of Rhode Island, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-800-831-2400.

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

www.BCBSRI.com

500 Exchange Street • Providence, RI 02903-2699

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