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

UnitedHealthcare Dental operated by Dental Benefit Providers, Inc.

Consumer Disclosure

Safe and Healthy Lives in Safe and Healthy Communities

Consumer Disclosure

CONSUMER'S RIGHT TO KNOW ABOUT HEALTH PLANS

THE HEALTH CARE ACCESSIBILITY AND QUALITY ASSURANCE ACT

WHY ARE YOU GETTING THIS INFORMATION?

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

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

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

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

Q **Who can I contact at the Health Plan for information?** Representatives of this Health Plan are available to help you get the information you need. You can contact a Health Plan representative at:

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UnitedHealthcare Dental / Dental Benefit Providers, Inc.
Member Services
1-877-816-3596

Appeals and Claim Address
PO Box 30567
Salt Lake City, UT 84130-0567

Para contractor a un representative que hable Espanol, llame a Nombre del Representte del Plan
1-877-816-3596

Q **How does the Health Plan review and approve covered services?** A Health Plan may review covered services that are recommended by providers to decide if the services are medically

necessary. If the plan decides the service is not medically necessary, it will not pay. You and your provider can appeal the Health Plan's decision. For more information about appeals see the Consumer's Guide to Health Plans in Rhode Island.

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

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

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If there is an emergency, seek dental care treatment immediately. If you receive out-of-network care in an emergency, your out-of-network coverage will apply, unless the emergency is to alleviate pain.

Q **What if I refuse a referral to a participating provider? (a doctor, nurse, or other health professional in your Health Plan's network)** (not applicable to single service Health Plans) When a specific covered service is recommended, Health Plans may send you to certain participating

providers. If you refuse the referral and get the service from another provider, the Health Plan must tell you what effect it will have on payment.

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Because this Plan is a single service (dental) Health Plan, referrals to participating providers are not applicable to the covered benefits provided under your Group Dental Care Insurance Policy.

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

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No, the Health Plan does not require a second opinion before it will pay for covered services. If you want a second opinion, the Health Plan would not pay for the cost of the second opinion.

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

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The Health Plan requires all providers and vendors with whom it works to contractually agree to comply with all applicable state and federal laws respecting the confidentiality of information concerning the medical histories, financial, dental, administrative, and other records pertaining to Members acquired in the course of providing or arranging for dental benefits. Providers are additionally required to exercise their best efforts to prevent any other person involved in doing business with them from disclosing, using or transmitting to any other person or entity any of the above described information.

Q **How am I protected from discrimination?** You have the right to be treated fairly and equally. Health Plans may not discriminate against you due to age, sex, religion, race or ethnic origin, disability, occupational status or any other characteristics protected by law.

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The Health Plan will not differentiate or discriminate in the treatment or in quality of services delivered to Members on the basis of race, sex, age, religion, place of residence, health status or source of payment, and shall observe, protect, and promote the rights of Members.

Q **If I refuse treatment, will it affect my future treatment?** If you refuse to be treated for any condition, your Health Plan must tell you what effect your decision will have on future coverage.

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Members have the right to refuse treatment. If you refuse treatment, it will not affect future treatment.

Q **How does the health plan pay providers?** Your Health Plan must tell you about the kinds of financial arrangements it has with providers.

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The Health Plan pays its In-Network, contracted providers a percentage of a negotiated rate for each procedure performed. Out-of-network providers are paid a percentage based upon prevailing local reasonable and customary amounts. Patients contribute co-insurance payments and deductibles toward the provider's total compensation by procedure. This health plan is not capitated and does not contain other risk sharing arrangements.

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

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The Health Plan will renew Member's coverage on the Member employer's contract anniversary date. Your coverage may be canceled if your employer fails to pay the premiums. There are also situations when a covered person's coverage can be canceled. You should contact the Member Services Department for further information.

Q **If I am covered by two or more Health Plans, what should I do?** If you or a family member are covered by two or more Health Plans, you may have to give information on your coverage to each Health Plan. This helps the Health Plans to arrange payments between the plans when you or a family member receive a service. Here's what this plan will ask you to tell them.

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If you or one of your enrolled dependants is covered under another dental plan, this Health Plan needs to know the following: name of the other insurance company, name of the policy holder, policy or ID number, family members covered. In addition, this Health Plan contains a coordination of benefits provision. As a result, if you are covered by two or more plans, benefits under the other plans may be taken into consideration when determining the benefits payable under this Health Plan.

Health Benefits Required Under Rhode Island Law as of September 2000:
Health Maintenance Organizations (HMOs) and health insurers in Rhode Island are required by State law to provide enrollees with coverage for certain kinds of health care services. These laws do not apply to Medicare, Medicaid, ERISA self-funded plans or supplemental (e.g. Medigap) or single disease (e.g. Cancer coverage) health insurance policies (check with your workplace benefits administrator. These mandated benefits (see summary list in Consumer's Guide to Health Plans in RI) often apply only under certain circumstances, may be limited to participating providers, and are not always covered in full--other conditions and restrictions not mentioned here may apply. For more information about specific mandated benefits, contact your Health Plan representative or the Rhode Island Department of Business Regulation at 401 222-2223.

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

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

- Health Plans
- Out-of-pocket costs
- Limits on services