Date: 09/21/2018

To: UMASS LOWELL STUDENT BLUE

Documents Provided: Subscriber Certificate(s) and Riders as of 08/01/2018

Attached are the Blue Cross Blue Shield of Massachusetts Subscriber Certificate(s) and associated riders for your health plan. While the Subscriber Certificate(s) and riders provide complete and detailed benefit information, they may not include information that you, as the sponsor of a group health plan, may need to comply with your statutory or regulatory notice obligations under ERISA or other applicable law. For example, these documents may not include all the information required under ERISA to be in a "summary plan description". In addition, these documents do not constitute a complete Evidence of Coverage as defined under Massachusetts state law and regulations.

Blue Cross and Blue Shield of Massachusetts, Inc. or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. administers your health plan benefits in accordance with the terms contained in this Subscriber Certificate(s) and associated riders. In the event of a dispute between any description prepared by you and the Subscriber Certificate(s) and associated riders, this Subscriber Certificate(s) and associated riders will govern.

The Subscriber Certificate(s) and associated riders are accurate as of 08/01/2018.

As you use this information, please keep in mind that Blue Cross and Blue Shield of Massachusetts, Inc. has a copyright on these documents. In addition, the use of these documents is for your plan administration purposes only. Please do not pass these documents on to any other person or entity for any other purpose unless authorized by Blue Cross and Blue Shield of Massachusetts, Inc. or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

attached to and made part of
Blue Cross and Blue Shield of Massachusetts, Inc.
Dental Blue Policy
BCBS-DENT (1-1-2014)

Schedule of Dental Benefits

Pediatric Essential Benefits

This is the *Schedule of Dental Benefits* that is a part of your Dental Blue Policy. This schedule describes the dental services that are covered by your Dental Blue Policy for *members* who are eligible for pediatric essential dental benefits. It also shows the cost-sharing amounts you must pay for these *covered services*. Do not rely on this schedule alone. **You should read all parts of your Dental Blue Policy to become familiar with the key points. Be sure to read the descriptions of *covered services* and the limitations and exclusions.** You should keep your Dental Blue Policy and this *Schedule of Dental Benefits* handy so that you can refer to them. The words that are shown in italics have special meanings. These words are explained in Part 8 of your Dental Blue Policy.

Who Is Eligible for Pediatric Essential Dental Benefits

The dental benefits described in this *Schedule of Dental Benefits* are provided for a *member* only until the end of the calendar month in which the *member* turns age 19.

Annual Deductible

Your *deductible* each *plan year*:	$50 per *member* (no more than $150 for three or more *members* who are eligible for pediatric essential dental benefits and who are enrolled under the same family membership)

The *deductible* is the cost you have to pay during the annual coverage period (as shown above) before benefits will be paid. The *deductible* applies to Group 2 and Group 3 services only. A *deductible* does not apply to Group 1 services or to Orthodontic services. See the chart that starts on the next page for how much you pay for *covered services* you receive after you meet the *deductible* (when it applies).

Annual Out-of-Pocket Maximum

Your *out-of-pocket maximum* each *plan year*:	$350 per *member* (no more than $700 for two or more *members* who are eligible for pediatric essential dental benefits and who are enrolled under the same family membership)

Your *out-of-pocket maximum* is the most you could pay during the annual coverage period (as shown above) for your share of the costs for *covered services*—your cost-sharing amounts. This *out-of-pocket maximum* helps you plan for health care expenses. Even though you pay the following costs, they do not count toward your *out-of-pocket maximum*: your *premiums*; any *balance-billed* charges; all costs for dental services for *members* who are not eligible for pediatric essential dental benefits; and all services this dental plan does not cover.

Schedule of Dental Benefits (continued)

Pediatric Essential Benefits

Annual Overall Benefit Limit for What the Plan Pays

Your overall benefit limit:	None

You do not have an overall benefit limit for pediatric essential dental benefits. But, there are limits that apply for specific *covered services*, such as for periodic oral exams. Some of these limits are described in this *Schedule of Dental Benefits* in the chart that starts below. **Do not rely on this chart alone.** Your dental policy along with this *Schedule of Dental Benefits* fully describes all of the limits and exclusions that apply for your dental benefits. Be sure to read all parts of your dental policy.

What You Pay for Covered Services—Your Cost-Sharing Amounts

You should be sure to read all parts of your dental policy—including this *Schedule of Dental Benefits*—to understand the requirements that you must follow to receive your dental benefits. You will receive these dental benefits as long as:

- You are a *member* who is eligible to receive pediatric essential dental benefits.
- Your dental service is a *covered service* as described in this *Schedule of Dental Benefits.*
- Your dental service is *necessary and appropriate*.
- Your dental service conforms to *Blue Cross and Blue Shield utilization review* guidelines.
- You use a *participating dentist* to get a *covered service*. (The only exceptions are noted in your dental policy.)

Covered Services for Members Under Age 19		Your Cost Is*:
Group 1— Preventive Services and Diagnostic Services		No charge
Oral exams	• One complete initial oral exam per provider or location (includes initial history and charting of teeth and supporting structures) • Periodic or routine oral exams; twice in a calendar year • Oral exams for a *member* under age three; twice in a calendar year • Limited oral exams; twice in a calendar year	
X-rays	• Single tooth x-rays; no more than one per visit • Bitewing x-rays; twice in a calendar year • Full mouth x-rays; once in three calendar years per provider or location • Panoramic x-rays; once in three calendar years per provider or location	
Routine dental care	• Routine cleaning, minor scaling, and polishing of the teeth; twice in a calendar year • Fluoride treatments; once in 90 days • Sealants; once per tooth in three years per provider or location (sealants over restored tooth surfaces not covered) • Space maintainers	
Group 2—Basic Restorative Services		25% of *allowed charge* after *deductible*
Fillings	• Amalgam (silver) fillings; one filling per tooth surface in 12 months • Composite resin (white) fillings; one filling per tooth surface in 12 months	

Schedule of Dental Benefits (continued)

Pediatric Essential Benefits

Covered Services for Members Under Age 19		Your Cost Is*:
Group 2—Basic Restorative Services (continued)		25% of *allowed charge* after *deductible*
Root canal treatment	• Root canals on permanent teeth; once per tooth • Vital pulpotomy • Retreatment of prior root canal on permanent teeth; once per tooth in 24 months • Root end surgery on permanent teeth; once per tooth	
Crowns (see also Group 3)	• Prefabricated stainless steel crowns; once per tooth (primary and permanent)	
Gum treatment	• Periodontal scaling and root planing; once per quadrant in 36 months • Periodontal surgery; once per quadrant in 36 months	
Prosthetic maintenance	• Repair of partial or complete dentures and bridges; once in 12 months • Reline or rebase partial or complete dentures; once in 24 months • Recementing of crowns, inlays, onlays, and fixed bridgework; once per tooth	
Oral surgery	• Simple tooth extractions; once per tooth • Erupted or exposed root removal; once per tooth • Surgical extractions; once per tooth (approval required for complete, boney impactions) • Other necessary oral surgery	
Other necessary services	• Dental care to relieve pain (palliative care) • General anesthesia for covered oral surgery	
Group 3—Major Restorative Services		50% of *allowed charge* after *deductible*
Crowns	• Resin crowns; once per tooth in 60 months • Porcelain/ceramic crowns; once per tooth in 60 months • Porcelain fused to metal/high noble crowns; once per tooth in 60 months	
Tooth replacement	• Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 84 months • Fixed prosthetics, only if there is no other less expensive adequate dental service; once in 60 months	
Other necessary services	• Occlusal guards when necessary; once in calendar year • Fabrication of an athletic mouth guard	

Schedule of Dental Benefits (continued)

Pediatric Essential Benefits

Covered Services for Members Under Age 19		Your Cost Is*:
Orthodontic Services		50% of *allowed charge*
Medically necessary orthodontic care that has been preauthorized for a qualified *member*	• Braces for a *member* who has a severe and handicapping malocclusion • Related orthodontic services for a *member* who qualifies	

***Important Note:** Your benefits will be calculated based on the *allowed charge*. In most cases, you will not have to pay charges that are more than the *allowed charge* when you use a *participating dentist* to furnish *covered services*. But, when you use a non-*participating dentist*, you may also have to pay all charges that are in excess of the *allowed charge* for *covered services*. This is called "*balance billing*." Refer to your dental policy for a more complete description of "*allowed charge.*"

MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Dental Blue Policy

This *Blue Cross and Blue Shield* Dental Blue Policy explains your dental benefits and the terms of your enrollment for these dental benefits. It describes your responsibilities to receive dental benefits and *Blue Cross and Blue Shield's* responsibilities to you. **This Dental Blue Policy has a *Schedule of Dental Benefits* that includes the list of *covered services* and the cost-sharing amounts you must pay for *covered services*. It also describes the *member* age restriction to receive these dental benefits.** You should read all parts of this Dental Blue Policy, including your *Schedule of Dental Benefits* to become familiar with the key points. You should keep them handy so that you can refer to them. The words that are shown in italics have special meanings. These words are explained in Part 8 of this Dental Blue Policy.

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Blue Cross and Blue Shield of Massachusetts, Inc.

Andrew Dreyfus
President

BLUE CROSS AND BLUE SHIELD OF MASSACHUSETTS, INC. 1937

Stephanie Lovell
Clerk/Secretary

Incorporated under the laws of the
Commonwealth of Massachusetts as a Non-Profit Organization

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English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call Member Services at the number on your ID Card (TTY: **711**).

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

Chinese/简体中文: 注意：如果您讲中文，我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部（TTY 号码：**711**）。

Haitian Creole/Kreyòl Ayisyen: ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantitifkasyon w lan (Sèvis pou Malantandan TTY: **711**).

Vietnamese/Tiếng Việt: LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: **711**).

Russian/Русский: ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: **711**).

Arabic/ةيبر:

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هُويتك (جهاز الهاتف النصي للصم والبكم "TTY": **711**).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិក តាមលេខនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (TTY: **711**)។

French/Français: ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (TTY : **711**).

Italian/Italiano: ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: **711**).

Korean/한국어: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: **711**)를 사용하여 회원 서비스에 전화하십시오.

Greek/Ελληνικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: **711**).

Polish/Polski: UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: **711**).

Hindi/हिंदी: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए नि:शुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई.: **711**).

Gujarati/ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને કૉલ કરો (TTY: **711**).

Tagalog/Tagalog: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID Card (TTY: **711**).

Japanese/日本語: お知らせ：日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください（TTY: **711**）。

German/Deutsch: ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: **711**).

Persian/پارسیان:
توج: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: **711**).

Lao/ພາສາລາວ: ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວ,ໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'dééʼ nóomba biká'ígíijį' béésh bee hodíílnih (TTY: **711**).

Part 1

Dental Benefits

You will receive the dental benefits described in this Dental Blue Policy as long as:

- You are a *member* who is eligible to receive these dental benefits.
- Your dental service is a *covered service*.
- Your dental service is *necessary and appropriate* as determined by *Blue Cross and Blue Shield*.
- Your dental service conforms to *Blue Cross and Blue Shield* dental guidelines and *utilization review*.
- You use a *participating dentist* to get a *covered service* (except as noted below).

Important Note: The term "you" refers to the *member* who has the right to the dental benefits described in this Dental Blue Policy. **The age restriction for a *member* to receive these dental benefits is shown in your *Schedule of Dental Benefits* that is part of this Dental Blue Policy.**

Obtaining Services from a Participating Dentist

In most cases, the dental benefits described in this Dental Blue Policy are provided only when you get *covered services* from a *participating dentist*. **To find a *participating dentist*, you should use the most current directory of dentists for the area where you choose to get your dental care.** To find a *participating dentist* in Massachusetts or in Rhode Island, look in the most up to date Dental Blue Directory of Providers. To find a *participating dentist* in other areas, look in the most up to date Out-of-Area Dental Provider Directory. If you need help to find a *participating dentist*, you can call the *Blue Cross and Blue Shield* customer service office. Or, you can call the Physician Selection Service at 1-800-821-1388. You can also use the online provider directory search that is on the *Blue Cross and Blue Shield* internet Web site at **www.bluecrossma.com**. Before you get your dental care, you should check with your dentist to make sure he or she is still a *participating dentist*.

There will be a few times when you may not be able to use a *participating dentist*. If this does happen, *Blue Cross and Blue Shield* will provide benefits for *covered services* you get from a non-*participating dentist.* These few times include **only when**:

- You have an emergency and a *participating dentist* is not reasonably available to you.
- You are outside Massachusetts and a *participating dentist* is not reasonably available to you.
- You are a *member* with a terminal illness and your *participating dentist* is involuntarily disenrolled as a *Blue Cross and Blue Shield participating dentist* for other than quality-related reasons or fraud. In this case, *Blue Cross and Blue Shield* will continue to provide benefits for *covered services* in connection with the terminal illness until the *member's* death. (Terminally ill means the *member* is expected to live six months or less as determined by a physician.)

If you need care outside Massachusetts and you use a non-*participating dentist*, the dentist must be licensed in a jurisdiction having licensing requirements substantially similar to those in Massachusetts. And, he or she must meet the same educational and clinical standards that *Blue Cross and Blue Shield* has for a *participating dentist*. **When benefits are provided for the non-*participating dentist*, you will be responsible for the amount of the dentist's charge that is in excess of the *allowed charge*. This *balance bill* is in addition to the cost sharing amounts you must pay.**

Except as described in this section, no benefits are provided for services that are furnished by a non-*participating dentist*.

What You Pay for Covered Services

The cost-sharing amount you pay for a *covered service* (such as a *deductible*, a *copayment*, and/or *coinsurance*) is shown in your *Schedule of Dental Benefits*. It also describes the age restriction for a *member*

to receive these dental benefits. Do not rely on this schedule alone. Be sure to read all parts of your Dental Blue Policy to understand the requirements that you must follow to receive all of your dental benefits. You should also read the descriptions of *covered services* and the limitations and exclusions that apply for these dental benefits. These provisions are fully described in your Dental Blue Policy.

Pre-Treatment Estimates

You do not need a pre-approval for dental services in order to get your dental benefits. But, your dentist may choose to send a pre-treatment estimate request to *Blue Cross and Blue Shield* in order to determine the extent to which your proposed dental services are covered. A pre-treatment estimate is a detailed description of the service that the dentist plans to perform and it includes the charge for the service. *Blue Cross and Blue Shield* recommends that your dentist send a pre-treatment estimate request for a service that he or she expects to cost more than $250. *Blue Cross and Blue Shield* will let you and your dentist know about your benefits for the services reported. A pre-treatment estimate is made based on current benefits and eligibility for these benefits. A pre-treatment estimate is not a guarantee of claim payment. Your dental benefits are paid based on the benefits and eligibility provisions that are in effect at the time the service is completed and a claim is sent for payment. If your dentist does not send a pre-treatment estimate request, *Blue Cross and Blue Shield* will decide your dental benefits based on a review of those services and the standards that are considered generally accepted dental practice.

Multi-Stage Dental Procedures

For some dental services, such as root canals and crowns, you will need to visit the dentist more than one time for it to be completed. These services will be covered by this Dental Blue Policy **only** if you are an eligible *member* on the date the *covered service* is completed. You do not have to be eligible for these benefits on the date the service is started. But, if your coverage under this Dental Blue Policy ends before the date the service is completed, no benefits are provided for the entire service.

How Your Benefits Are Calculated

Blue Cross and Blue Shield calculates the payment of your dental benefits based on the *allowed charge*. The *allowed charge* depends on the type of dental provider that you use for your *covered services*.

- **Participating dentists:** For *covered services* that are furnished by a dentist who has a payment arrangement to provide dental services to eligible *members* covered by this Dental Blue Policy, *Blue Cross and Blue Shield* will calculate your benefits based on the provisions of the *participating dentist's* payment agreement and the contract rate that is in effect at the time the *covered service* is furnished. This contract rate is referred to as the dentist's *allowed charge*. **In most cases, you do not have to pay the amount of the *participating dentist's* actual charge that is in excess of the** *allowed charge***.** But, there are certain times when you will have to pay the difference between the *allowed charge* and the *participating dentist's* actual charge (this is known as "*balance billing*"). You will have to pay this *balance bill* if any of the following situations happen: (1) you and your dentist decide to use a procedure that is more expensive than a less costly but approved alternative and *Blue Cross and Blue Shield* provides benefits toward the cost of the procedure with the lower fee; or (2) you could have received benefits or services from someone else without a charge or you have received or will receive payment from another person or insurance company until those benefits are used up; or (3) you receive services from more than one dentist for the same procedure or for procedures furnished in a series during a planned course of treatment and *Blue Cross and Blue Shield* has paid the amount that would have been provided had only one dentist furnished all of the services.

- **Non-participating dentists:** For *covered services* that are furnished by a non-*participating dentist*, *Blue Cross and Blue Shield* will calculate your dental benefits based on the usual and customary charge (also referred to as the "*allowed charge*"). The usual and customary charge is based on 80% of

the *Blue Cross and Blue Shield* Maximum Allowable Charge for each specific *covered service*, but no more than 80% of the dentist's actual charge. The usual and customary charge is less than the dentist's actual charge. **You will be responsible for the amount of the dentist's actual charge that is in excess of the usual and customary charge (known as "*balance billing*").** You must pay this *balance bill* amount in addition to your cost-sharing amounts.

Covered Services

Your *Schedule of Dental Benefits* describes the dental services that are covered by this Dental Blue Policy for eligible *members*. It also describes the age restrictions and the frequency limits for *covered services*.

Excluded Services and Charges

No benefits are provided under this Dental Blue Policy for:

- Cast restorations, copings, or attachments for installing overdentures, including associated endodontic procedures such as root canals, precision attachments, semiprecision attachments, or copings.
- Drugs, pharmaceuticals, biologicals, or other prescription agents or products.
- Duplicate dentures or bridges.
- Fillings on tooth surfaces where a sealant was applied within the prior 12 months.
- Free care; or care that would be free if you were not covered under this Dental Blue Policy.
- Incomplete procedures or treatments.
- Lab tests or bacteriological tests.
- Labial veneers.
- Nitrous oxide or sedation.
- Nutrition counseling.
- Photographs.
- Sealants that are applied to permanent premolar or molar surfaces that have decay or fillings.
- Implants or transplants, or any related surgical or restorative procedures.
- A charge that is for, or related to, a service that *Blue Cross and Blue Shield* considers to be experimental. The service must be documented by controlled studies that determine its merits (such as its safety) and include sufficient follow-up studies.
- A charge that is for a service, supply, procedure, or appliance for reasons such as theft, abuse, misuse, misplacement, loss, improper fit, allergies, breakage, or ingestion.
- A charge for a visit that you do not keep. A dentist may charge you if you fail to keep your planned visit if you do not give his or her office reasonable notice.
- A charge for a service for which you have the right to benefits under government programs. These programs include: the Veterans Administration for an illness or injury connected to military service; and programs set up by other local, state, federal, or foreign laws or regulations that provide or pay for health care services and supplies or that require care to be furnished in a public facility. Except for Medicaid or Medicare, no benefits are provided if you could have received governmental benefits by applying for them on time.
- A consultation by a dentist who also performs the service.
- A method of treatment that is more costly than is usually provided. If *Blue Cross and Blue Shield* determines that your service is more costly than another acceptable alternative service, *Blue Cross and Blue Shield* will provide benefits for the least expensive but acceptable alternative service that meets your needs. In this case, you pay the difference between the *Blue Cross and Blue Shield allowed amount* and the dentist's actual charge (*balance bill*).
- A separate charge for occlusal analysis, pulp vitality testing, or pulp capping. These services are usually performed as part of another *covered service*.
- A service, supply, procedure, or appliance that is furnished along with, in preparing for, or as a result of a non-*covered service*.

- A service, supply, procedure, or appliance that is furnished to someone other than the patient.
- A service and a related service, supply, procedure, or appliance that is required by a third party.
- A service, supply, procedure, or appliance to stabilize teeth when it is due to periodontal disease.
- A service, supply, procedure, or appliance to diagnose or treat temporomandibular joint disorders or muscular pain, including grinding of the teeth.
- A service, supply, procedure, or appliance when its sole purpose is to increase the height of teeth or to restore occlusion.
- A service, supply, procedure, or appliance that is cosmetic in nature or meant primarily to change or improve your appearance.
- A service, supply, procedure, or appliance to treat congenital anomalies.
- Any service, supply, procedure, or appliance that is not described as a *covered service*.
- A service, supply, procedure, or appliance furnished after your termination date under this Dental Blue Policy.
- A service, supply, procedure, or appliance furnished by a dentist to himself or herself or to a member of his or her immediate family. “Immediate family” means any of the following members of a dentist’s family: spouse or spousal equivalent; parent, child, brother or sister (by birth or adoption); stepparent, stepchild, stepbrother or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law or sister-in-law (for purposes of this exclusion, an in-law relationship does not exist between the dentist and the spouse of his or her wife’s or husband’s brother or sister); and grandparent or grandchild. The immediate family members listed above will still be considered immediate family after the marriage which created the relationship is ended by divorce or death.
- A dentist’s charge for shipping and handling or taxes.
- A dentist’s charge to file a claim. Also, a dentist’s charge to transcribe or copy your dental records.

Part 2
Member Services

How to Get Help for Questions

Blue Cross and Blue Shield can help you to understand the terms of your Dental Blue Policy. You can call or write to the *Blue Cross and Blue Shield* customer service office. A *Blue Cross and Blue Shield* customer service representative will work with you to resolve your problem or concern as quickly as possible. *Blue Cross and Blue Shield* will keep a record of each inquiry you, or someone on your behalf, makes to *Blue Cross and Blue Shield*. *Blue Cross and Blue Shield* will keep these records, including the answers to each inquiry, for two years. These records may be reviewed by the Commissioner of Insurance and the Massachusetts Department of Public Health.

- **If You Are Enrolled as a Group Member:** If you are enrolled as a *group member* under this Dental Blue Policy, you can call Monday through Friday from 8:00 a.m. to 8:00 p.m. (Eastern Time). The toll free phone number to call is shown on your ID card. (For TTY, call 711.) Or, you can write to: Blue Cross Blue Shield of Massachusetts, Member Service, P.O. Box 9134, North Quincy, MA 02171-9134.

- **If You Are Enrolled as a Direct Pay Individual Member:** If you enrolled as a direct pay individual *member* under this Dental Blue Policy, you can call Monday through Friday from 8:00 a.m. to 6:00 p.m. (Eastern Time). The toll free phone number to call is shown on your ID card. (For TTY, call 711.) Or, you can write to: Blue Cross Blue Shield of Massachusetts, Member Service, P.O. Box 9140, North Quincy, MA 02171-9140.

When You Need Help to Find a Participating Dentist

A *Blue Cross and Blue Shield* customer service representative can help you find a *participating dentist*. The toll-free phone number is shown on your ID card. Or, you can call the Physician Selection Service at 1-800-821-1388. You can also use the online provider directory "Find a Doctor" that is on the *Blue Cross and Blue Shield* internet Web site at www.bluecrossma.com.

What to Do in an Emergency

At the onset of an emergency medical condition that in your judgment requires emergency medical care, you should go to the nearest emergency room. For assistance, call 911 or your local emergency phone number. You can also see a *participating dentist* when you have a dental emergency. You should ask your dentist how to contact him or her in an emergency. If you are away from home, you can call the *Blue Cross and Blue Shield* customer service office for help to find a *participating dentist* in the area.

Discrimination Is Against the Law

Blue Cross and Blue Shield complies with applicable federal civil rights laws and does not discriminate on the basis of race; color; national origin; age; disability; sex; sexual orientation; or gender identity. *Blue Cross and Blue Shield* does not exclude people or treat them differently because of race; color; national origin; age; disability; sex; sexual orientation; or gender identity.

Blue Cross and Blue Shield provides:

- Free aids and services to people with disabilities to communicate effectively with *Blue Cross and Blue Shield*. These aids and services may include qualified sign language interpreters and written information in other formats (such as in large print).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your ID card.

If you believe that *Blue Cross and Blue Shield* has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the *Blue Cross and Blue Shield* Civil Rights Coordinator: by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; or by phone at 1-800-472-2689 (TTY: 711); or by fax at 1-617-246-3616; or by email at civilrightscoordinator@bcbsma.com. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights online at ocrportal.hhs.gov; or by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F HHH Building, Washington, DC 20201; or by phone at 1-800-368-1019 or 1-800-537-7697 (TDD). Complaint forms are available at www.hhs.gov.

Part 3
Claims Filing Procedures

Filing a Claim

Your *participating dentist* will file a claim for you when you receive a *covered service*. Just tell the *participating dentist* that you are a *member*. Show the *participating dentist* your ID card. Also, be sure to give the dentist any other information that is needed to file your claim. You must properly inform your dentist within 30 days after you receive the *covered service*. If you do not, benefits will not have to be provided. *Blue Cross and Blue Shield* will pay the *participating dentist* directly for *covered services*.

You may have to file your claim when you receive a *covered service* from a non-*participating dentist*. The non-*participating dentist* may ask you to pay the entire charge at the time of the visit or at a later time. It is up to you to pay the non-*participating dentist*. To file a dental claim, you must: fill out a claim form; attach your original itemized bills; and mail the claim to the *Blue Cross and Blue Shield* customer service office. When you have to file a claim, you can get claim forms from the *Blue Cross and Blue Shield* customer service office. *Blue Cross and Blue Shield* will mail to you all applicable forms within 15 days after receiving notice that you obtained some service or supply for which you may be paid. You must file a claim within two years of the date you received the *covered service*. *Blue Cross and Blue Shield* will not have to provide benefits for *covered services* for which a claim is submitted after this two-year period.

Timeliness of Claim Payments

Within 30 calendar days after *Blue Cross and Blue Shield* receives a completed request for benefits or payment, *Blue Cross and Blue Shield* will make a decision. When appropriate, *Blue Cross and Blue Shield* will make a payment to the *participating dentist* (or to you in certain cases) for your claim to the extent of your dental benefits. Or, *Blue Cross and Blue Shield* will send you and/or the dentist a notice in writing of why your claim is not being paid in full or in part. If the request for benefits or payment is not complete or, if *Blue Cross and Blue Shield* needs more information to make a final determination for the claim, *Blue Cross and Blue Shield* will ask for the information or records it needs. In this case, *Blue Cross and Blue Shield* will send their request within 30 calendar days of the date that they received the request for benefits or payment. The additional information they need must be provided to *Blue Cross and Blue Shield* within 45 calendar days of the date their request is sent. If the additional information is provided to *Blue Cross and Blue Shield* within 45 calendar days of their request, *Blue Cross and Blue Shield* will make a decision within the time remaining in the original 30-day claim determination period. Or, *Blue Cross and Blue Shield* will make the decision within 15 calendar days of the date they receive the additional information, whichever is later. If the additional information is not provided to *Blue Cross and Blue Shield* within 45 calendar days of their request, the request for benefits or payment will be denied by *Blue Cross and Blue Shield*. If the additional information is submitted to *Blue Cross and Blue Shield* after these 45 days, then it may be viewed by *Blue Cross and Blue Shield* as a new request for benefits or payment. In this case, *Blue Cross and Blue Shield* will make a decision within 30 days as described earlier in this section.

Part 4

Grievance Program

You have the right to a full and fair review when you disagree with a decision that is made by *Blue Cross and Blue Shield* to deny benefits or payment for a dental service; or you disagree with how your claim was paid; or you have a complaint about the service you received from *Blue Cross and Blue Shield* or a *participating dentist*; or you are denied coverage in this Dental Blue Policy; or your Dental Blue Policy is canceled or discontinued by *Blue Cross and Blue Shield* for reasons other than nonpayment of *premium*.

When making a determination under this Dental Blue Policy, *Blue Cross and Blue Shield* has full discretionary authority to interpret this Dental Blue Policy and to determine whether a dental service is a covered service under this Dental Blue Policy. All determinations by *Blue Cross and Blue Shield* with respect to benefits under this Dental Blue Policy will be conclusive and binding unless it can be shown that the interpretation or determination was arbitrary and capricious.

What to Do if You Have a Claim Problem or Complaint

Most problems or concerns can be handled with just one phone call. For help to resolve a problem or concern, you should first call the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your *Blue Cross and Blue Shield* ID card. A customer service representative will work with you to help you understand your dental benefits or to resolve your problem or concern as quickly as possible. When resolving a problem or concern, *Blue Cross and Blue Shield* will consider all aspects of the particular case. This includes looking at: all of the provisions of this Dental Blue Policy; the policies and procedures that support this Dental Blue Policy; the dental provider's input; and your understanding and expectation of dental benefits. *Blue Cross and Blue Shield* will use every opportunity to be reasonable in finding a solution that makes sense for all parties. *Blue Cross and Blue Shield* will follow its standard guidelines when it resolves your problem or concern. If after speaking with a *Blue Cross and Blue Shield* customer service representative, you still disagree with the decision that is given to you, you may request a review through *Blue Cross and Blue Shield's* formal grievance program. You may also request this type of review if *Blue Cross and Blue Shield* has not responded within three working days of receiving your inquiry. If this happens, *Blue Cross and Blue Shield* will notify you and let you know the steps you may follow to request a formal grievance review.

When and How to Request a Formal Grievance Review

To request a formal grievance review from the *Blue Cross and Blue Shield* Member Grievance Program, you (or your authorized representative) have three options:

- **To write or send a fax.** The preferred option is for you to send your grievance in writing to Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Or, you may fax your grievance to 1-617-246-3616. *Blue Cross and Blue Shield* will let you know that your request was received by sending you a written confirmation within 15 calendar days.

- **To send an e-mail.** You may send your grievance by e-mail to *Blue Cross and Blue Shield* Member Grievance Program at grievances@bcbsma.com. *Blue Cross and Blue Shield* will let you know that your request was received by sending you a confirmation immediately by e-mail.

- **To make a telephone call.** You may call the *Blue Cross and Blue Shield* Member Grievance Program at 1-800-472-2689. When your request is made by phone, *Blue Cross and Blue Shield* will send you a written account of the grievance within 48 hours of your phone call.

Once your request is received, *Blue Cross and Blue Shield* will research the case in detail. They will ask for more information if it is needed. *Blue Cross and Blue Shield* will let you know in writing of the decision or the outcome of the review. If your grievance is about termination of your coverage for concurrent services that were previously approved by *Blue Cross and Blue Shield*, the disputed coverage will continue until this grievance review process is completed. This continuation of your coverage does not apply to: services that are limited by a dollar or visit maximum and that exceed that benefit limit; non-*covered services*; or services that were received prior to the time that you requested a formal grievance review; or when a grievance is not received on a timely basis, based on the course of treatment.

All grievances must be received by *Blue Cross and Blue Shield* within one year of the date of treatment, event, or circumstance, such as the date you were told of the service denial or claim denial.

What to Include in a Grievance Review Request
Your request for a formal grievance review should include: the *member's* name, ID number, and daytime phone number; a description of the problem; all relevant dates; names of health care providers or administrative staff involved; and details of the attempt that has been made to resolve the problem. If *Blue Cross and Blue Shield* needs to review the medical or dental records and treatment information that relate to the grievance, *Blue Cross and Blue Shield* will promptly send you an authorization form to sign if needed. You must return this signed form to *Blue Cross and Blue Shield*. It will allow for the release of your medical records. You also have the right to look at and get copies (free of charge) of records and criteria that *Blue Cross and Blue Shield* has and that are relevant to your grievance, including the identity of any experts who were consulted.

Authorized Representative
You may choose to have another person act on your behalf during the grievance review process. You must designate this person in writing to *Blue Cross and Blue Shield*. Or, if you are not able to do this, a person such as a conservator, a person with power of attorney, or a family member may be your authorized representative. Or, he or she may appoint another party to be the authorized representative.

Who Handles the Grievance Review
All grievances are reviewed by professionals who are knowledgeable about *Blue Cross and Blue Shield* and the issues involved in the grievance. The professionals who will review your grievance will not be those who participated in any of *Blue Cross and Blue Shield's* prior decisions regarding the subject of your grievance, nor do they work for anyone who did. When a grievance is related to a *necessity and appropriateness* denial, at least one grievance reviewer is an individual who is an actively practicing health care or dental professional in the same or similar specialty who usually treats the condition or provides treatment that is the subject of your grievance.

Response Time
The review and response for *Blue Cross and Blue Shield's* formal grievance review will be completed within 30 calendar days. If your grievance review begins after an inquiry, the 30-day response time will begin on the day you tell *Blue Cross and Blue Shield* that you disagree with *Blue Cross and Blue Shield's* answer and would like a formal grievance review. Every reasonable effort will be made to speed up the review of grievances that involve dental services that are soon to be obtained by the *member*. With your permission, *Blue Cross and Blue Shield* may extend the 30-calendar-day time frame to complete a grievance review. This will happen in those cases when *Blue Cross and Blue Shield* and the *member* agree that additional time is required to fully investigate and respond to the grievance. *Blue Cross and Blue Shield* may also extend the 30-calendar-day time frame when the grievance review requires a review of your medical or dental records and *Blue Cross and Blue Shield* requires your authorization to get these records. The 30-day response time will not include the days from when *Blue Cross and Blue Shield* sends you the authorization form to sign until it receives your signed authorization form (if needed). If *Blue Cross and*

Blue Shield does not receive your authorization within 30 working days after your grievance is received, *Blue Cross and Blue Shield* may make a final decision about your grievance without that medical information. In any case, for a grievance review involving dental services that have not yet been obtained by you, *Blue Cross and Blue Shield* will ask for your permission to extend the 30-day time frame if it cannot complete the review within 30 calendar days of receipt of your grievance. A grievance that is not acted upon within the time frames specified by applicable federal or state law will be considered resolved in favor of the *member*.

Written Response
Once the grievance review is completed, *Blue Cross and Blue Shield* will let you know in writing of the decision or the outcome of the review. If *Blue Cross and Blue Shield* continues to deny benefits for all or part of a service, *Blue Cross and Blue Shield* will send an explanation to you. This notice will include: information related to the details of your grievance; the reasons that *Blue Cross and Blue Shield* has denied the request and the applicable terms of your Dental Blue Policy; the specific medical and scientific reasons for which *Blue Cross and Blue Shield* has denied the request; any alternative treatment or services and supplies that would be covered; and *Blue Cross and Blue Shield* clinical guidelines that apply and were used and any review criteria.

Grievance Records
You have the right to look at and get copies of records and criteria that *Blue Cross and Blue Shield* has and that are relevant to your grievance. These copies will be free of charge. *Blue Cross and Blue Shield* will maintain a record of all formal grievances, including the response for each grievance review, for up to seven years.

Expedited Review for Immediate or Urgently-Needed Services
You may have the right to request an "expedited" grievance review. You can do this when your grievance review concerns care for which waiting for a response under the grievance review time frames would seriously jeopardize your life or health or your ability to regain maximum function as determined by *Blue Cross and Blue Shield* or your physician. You may also request an expedited review if your physician says you will have severe pain that cannot be adequately managed if you do not receive the care that is the subject of the grievance review. If you request an expedited review, *Blue Cross and Blue Shield* will review your grievance and notify you of the decision within 72 hours after your request is received, or such shorter time period as required by federal law.

Appeals Process for Rhode Island Residents or Services

You may also have the right to an appeal as described in this section when a claim is denied as being not *necessary and appropriate*. Your right to this appeal is in addition to the other rights to appeal as described earlier in this Dental Blue Policy. You have the right to this appeal only if you (1) live outside of Rhode Island; and (2) you want to obtain services in Rhode Island that *Blue Cross and Blue Shield* has determined are not *necessary and appropriate* for you.

The first step in this process is a reconsideration. If you receive a letter from *Blue Cross and Blue Shield* that denies payment for your services, you may ask that *Blue Cross and Blue Shield* reconsider its decision. To do this, you must send a letter to ask for this review to: Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Your letter must be sent within 180 days of *Blue Cross and Blue Shield's* adverse decision. Along with your letter, you should send any information that will support your request. *Blue Cross and Blue Shield* will review your request and let you know the outcome within 15 calendar days after they have received all information needed for the review.

The second step is an appeal. If *Blue Cross and Blue Shield* continues to deny benefits for all or a part of the service, you may ask for an appeal. You must ask for this appeal within 60 days of the date that you

receive the reconsideration denial letter from *Blue Cross and Blue Shield*. Your appeal request should include any information that supports your appeal. You may also inspect and add information to your *Blue Cross and Blue Shield* case file to prepare your appeal. According to Rhode Island state law, if you wish to review the information in your *Blue Cross and Blue Shield* case file, you must make your request in writing and you must include the name of a dentist who may review your case file on your behalf. Your dentist may review, interpret, and disclose any or all of that information to you. Once *Blue Cross and Blue Shield* receives your appeal, your appeal will be reviewed by a dentist in the same specialty as your attending dentist. *Blue Cross and Blue Shield* will notify you of the outcome of your appeal within 15 calendar days after they have received all information needed for the appeal.

If your appeal is denied, you have the right to present your case to an appeals agency that is designated by Rhode Island and not affiliated with *Blue Cross and Blue Shield*. If you request this voluntary external appeal, Rhode Island requires that you pay for half of the cost of the appeal. *Blue Cross and Blue Shield* will pay for the remaining half. The notice you receive from *Blue Cross and Blue Shield* about your appeal will advise you of: the name of the appeals agency that is designated by Rhode Island; and your share of the cost for an external appeal. To file an external appeal, you must make your request in writing to: Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Along with your request, you must: state your reason(s) for why you disagree with *Blue Cross and Blue* Shield's decision; and enclose a check made payable to the designated appeals agency for your share of the cost for the external appeal. Within five working days after *Blue Cross and Blue Shield* receives your written request and payment for the appeal, *Blue Cross and Blue Shield* will forward your request to the external appeals agency. *Blue Cross and Blue Shield* will also send their part of the fee and your entire *Blue Cross and Blue Shield* case file. The external appeals agency will notify you in writing of the decision within ten working days of receiving all necessary information.

If your situation is an emergency, you have the right to an "expedited" appeal at all three levels of appeal as stated above. You may request an expedited reconsideration or appeal by calling *Blue Cross and Blue Shield* at the phone number shown in your letter. *Blue Cross and Blue Shield* will notify you of the result of your expedited appeal within two working days or 72 hours of its receipt, whichever is sooner. If your appeal is denied, you have the right to request an expedited external appeal. The notice you receive from *Blue Cross and Blue Shield* about your appeal will advise you of: the name of the appeals agency that is designated by Rhode Island; and the amount that Rhode Island requires you pay for your share of the cost for an expedited external appeal. To request an expedited external appeal, you must send your request in writing to: Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Your request should state your reason(s) for why you disagree with the decision and include signed documentation from your dentist that describes the emergency nature of your treatment. In addition, you must also enclose a check made payable to the designated appeals agency for your share of the cost for the expedited external appeal. Within two working days after the receipt of your written request and payment for the appeal, *Blue Cross and Blue Shield* will forward your request to the external appeals agency along with *Blue Cross and Blue Shield's* part of the fee and your entire *Blue Cross and Blue Shield* case file. The external appeals agency will notify you in writing of the decision within two working days or 72 hours, whichever is sooner, of receiving your request for a review.

If the external appeals agency upholds the original decision of *Blue Cross and Blue Shield*, this completes the appeals process for your case. But, if the external appeals agency reverses *Blue Cross and Blue Shield's* decision, the claim in dispute will be reprocessed by *Blue Cross and Blue Shield* upon receipt of the notice of the final appeal decision. And, *Blue Cross and Blue Shield* will repay you for your share of the cost for the external appeal within 60 days of the receipt of the notice of the final appeal decision.

Part 5
Other General Provisions

Access to and Confidentiality of Dental and Medical Records

Blue Cross and Blue Shield and health care and dental providers may, in accordance with applicable law, have access to all of your medical and dental records and related information that is needed by *Blue Cross and Blue Shield* or the health care or dental providers. *Blue Cross and Blue Shield* may collect information from health care and dental providers or from other insurance companies or, for *group members*, from the *plan sponsor*. *Blue Cross and Blue Shield* will use this information to help them administer the benefits described in this Dental Blue Policy. They will also use it to get facts on the quality of care that is provided under this and other health care and dental plans. In accordance with law, *Blue Cross and Blue Shield* and health care and dental providers may use this information, and may disclose it to necessary persons and entities as follows: (1) for administering benefits (including coordination of benefits with other insurance or health benefit plans), disease management programs, managing care, quality assurance, utilization management, the prescription drug history program, grievance and claims review activities, or other specific business, professional, or insurance functions for *Blue Cross and Blue Shield*; (2) for bona fide medical research according to the regulations of the U.S. Department of Health and Human Services and the U.S. Food and Drug Administration for the protection of human subjects; (3) as required by law or valid court order; (4) as required by government or regulatory agencies; and (5) for *group members*, as required by the *subscriber's group* or by its auditors to make sure that *Blue Cross and Blue Shield* is administering this Dental Blue Policy properly.

Blue Cross and Blue Shield will not share information about you with the Medical Information Bureau (MIB). *Blue Cross and Blue Shield* respects your right to privacy. *Blue Cross and Blue Shield* will not use or disclose personally identifiable information about you without your permission, unless the use or disclosure is permitted or required by law and is done in accordance with the law. You have the right to get the information *Blue Cross and Blue Shield* collects about you. You may also ask *Blue Cross and Blue Shield* to correct any of this information that you believe is not correct. *Blue Cross and Blue Shield* may charge you a reasonable fee for copying your records, unless your request is because *Blue Cross and Blue Shield* is declining or terminating your coverage under this Dental Blue Policy.

Important Note: To get a copy of *Blue Cross and Blue Shield's* Commitment to Confidentiality statement, call the *Blue Cross and Blue Shield* customer service office.

Acts of Dentists

Blue Cross and Blue Shield is not liable for the acts or omissions by any dentist or other provider that furnishes care or services to you. A *participating dentist* or any other provider does not act as an agent on behalf of or for *Blue Cross and Blue Shield*. And, *Blue Cross and Blue Shield* does not act as an agent for a *participating dentist* or any other provider. *Blue Cross and Blue Shield* will not interfere with the relationship between providers and their patients. You are free to select or discharge any provider.

Assignment of Benefits

You cannot assign any benefit or monies due under this Dental Blue Policy to any person, corporation, or other organization without *Blue Cross and Blue Shield's* written consent. Any assignment by you will be void. Assignment means the transfer of your rights to the benefits under this Dental Blue Policy to another person or organization. There is one exception. If Medicaid has already paid the provider, you can assign your benefits to Medicaid.

Authorized Representative

You may choose to have another person act on your behalf concerning your benefits under this Dental Blue Policy. You must designate this person in writing to *Blue Cross and Blue Shield*. Or, if you are not able to do this, a person such as a conservator, a person with power of attorney, or a family member may be your authorized representative. In some cases, *Blue Cross and Blue Shield* may consider your dentist or other health care provider to be your authorized representative. For example, *Blue Cross and Blue Shield* may tell your dentist about the extent of your dental benefits for services reported on a pre-treatment estimate. Or, *Blue Cross and Blue Shield* may ask your dentist or physician for information if more is needed for *Blue Cross and Blue Shield* to make a decision. *Blue Cross and Blue Shield* will continue to send benefit payments and written communications regarding your dental benefits according to *Blue Cross and Blue Shield's* standard practices, unless you specifically ask *Blue Cross and Blue Shield* to do otherwise. You can get a form to designate an authorized representative from the *Blue Cross and Blue Shield* customer service office.

Changes to this Dental Blue Policy

Blue Cross and Blue Shield (or the *plan sponsor* when you are a *group member*) may change the provisions of this Dental Blue Policy. For example, a change may be made to your cost-sharing amounts for certain *covered services*. When *Blue Cross and Blue Shield* makes a material change to your Dental Blue Policy, *Blue Cross and Blue Shield* will send a notice about the change at least 60 days before the effective date of the change. This notice will describe the change being made. It will also give the effective date of the change. *Blue Cross and Blue Shield* will send this notice to the *subscriber* or to the *plan sponsor* when you are enrolled as a *group member*. When you are enrolled as a *group member*, the *plan sponsor* should deliver to its *group members* all notices from *Blue Cross and Blue Shield*.

Coordination of Benefits (COB)

Blue Cross and Blue Shield will coordinate payment of *covered services* with hospital, medical, dental, health, or other plans under which you are covered. *Blue Cross and Blue Shield* will do this to make sure that the cost of your health care services is not paid more than once. Other plans include: personal injury insurance; automobile insurance, including medical payments coverage; homeowner's insurance; and other plans that cover hospital or medical expenses. You must include information on your enrollment forms about other health plans under which you are covered. Once you are enrolled for coverage under this Dental Blue Policy, you must notify *Blue Cross and Blue Shield* if you add or change health plan coverage. Upon *Blue Cross and Blue Shield's* request, you must also supply *Blue Cross and Blue Shield* with information about other plans that may provide you with coverage for health care services.

Under COB, the plan that provides benefits first is known as the primary payor. And the plan(s) that provide benefits next are known as the secondary payor(s). When coverage under this Dental Blue Policy is secondary, no dental benefits will be provided until after the primary payor determines its share, if any, of the liability. *Blue Cross and Blue Shield* decides which is the primary and secondary payor. To do this, *Blue Cross and Blue Shield* relies on Massachusetts law, including the COB regulations issued by the Massachusetts Division of Insurance. A copy of these rules is available from *Blue Cross and Blue Shield* upon request. Unless otherwise required by law, the benefits of this Dental Blue Policy will be secondary when another plan provides you with benefits for dental services.

Blue Cross and Blue Shield will not provide any more dental benefits than those that are described in this Dental Blue Policy. *Blue Cross and Blue Shield* will not provide duplicate benefits for *covered services*. If *Blue Cross and Blue Shield* pays more than the amount that it should have under COB, then you must give that amount back to *Blue Cross and Blue Shield*. *Blue Cross and Blue Shield* has the right to get that amount back from you or any appropriate person, insurance company, or other organization.

Important Note: If you fail to comply with the provisions of this COB section, payment of your claim may be denied.

Pre-Existing Conditions

Your benefits are not limited based on medical conditions that are present on or before your effective date under this Dental Blue Policy. This means that *covered services* will be covered from your effective date. There is no pre-existing condition restriction or waiting period to receive benefits. But, benefits for *covered services* are subject to all the provisions of your Dental Blue Policy.

Quality Assurance Programs

Blue Cross and Blue Shield uses quality assurance and training programs and performance measures that are designed to ensure accuracy in claims processing. *Blue Cross and Blue Shield* also uses management and technology solutions to help customer service representatives resolve issues quickly and accurately.

Subrogation and Reimbursement of Benefit Payments

If you are injured by any act or omission of another person, the benefits provided under this Dental Blue Policy will be subrogated. This means that *Blue Cross and Blue Shield* may use your right to recover money from the person(s) who caused the injury or from any insurance company or other party. If you recover money, *Blue Cross and Blue Shield* is entitled to recover up to the amount of the benefit payments that it has made. This is true no matter where or by whom the recovered money is held or how it is designated and even if you do not recover the total amount of your claim against the other person(s). This is also true if the payment you receive is described as payment for other than dental expenses. The amount that you must reimburse to *Blue Cross and Blue Shield* will not be reduced by any attorney's fees or expenses that you incur. You must give *Blue Cross and Blue Shield* information and help. This means you must complete and sign all necessary documents to help *Blue Cross and Blue Shield* get this money back. This also means that you must give *Blue Cross and Blue Shield* timely notice of all significant steps during negotiation, litigation, or settlement with any third party (such as filing a claim or lawsuit, initiation of settlement discussions, agreement to a settlement in principle, etc.) and before settling any claim arising out of injuries you sustained by an act or omission of another person(s) for which *Blue Cross and Blue Shield* paid benefits. You must not do anything that might limit *Blue Cross and Blue Shield's* right to full reimbursement.

Time Limit for Legal Action

Before you pursue a legal action against *Blue Cross and Blue Shield* for any claim under this Dental Blue Policy, you must complete the *Blue Cross and Blue Shield* formal grievance review. If, after you complete the grievance review, you choose to bring a legal action against *Blue Cross and Blue Shield*, you must bring this action within two years after the cause of the action arises. For example, if you are filing a legal action because you were denied a service or a claim for benefits under this Dental Blue Policy, you will lose your right to bring a legal action against *Blue Cross and Blue Shield* unless you file your action within two years after the date of the decision of the final appeal of the service or claim denial. Going through the formal grievance review process does not extend the two-year limit for filing a lawsuit.

Part 6
Group Policy

This Part 6 applies to you when you enroll as a *group member* for coverage under this Dental Blue Policy. This means that the *subscriber's group* has an agreement (a group contract) with *Blue Cross and Blue Shield* to provide its *group members* with access to the dental benefits described in this Dental Blue Policy. The *group* must pay monthly *premiums* to *Blue Cross and Blue Shield* on behalf of its *group members* for this coverage. The *group* should also deliver to its *group members* all notices from *Blue Cross and Blue Shield*. The *group* is the *subscriber's* agent. The *group* is not the agent of *Blue Cross and Blue Shield*. If you are enrolled as a *group member*, you should contact your *plan sponsor* for enrollment or billing questions.

You hereby expressly acknowledge your understanding that the *group* contract constitutes a contract solely between your *group* on your behalf and Massachusetts, Inc. (*Blue Cross and Blue Shield*), which is a corporation independent of and operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting *Blue Cross and Blue Shield* to use the Blue Cross and Blue Shield Service Marks in the Commonwealth of Massachusetts, and that *Blue Cross and Blue Shield* is not contracting as the agent of the Association. You further acknowledge and agree that your *group* on your behalf has not entered into the *group* contract based upon representations by any person other than *Blue Cross and Blue Shield* and that no person, entity, or organization other than *Blue Cross and Blue Shield* will be held accountable or liable to you or your *group* on your behalf for any of *Blue Cross and Blue Shield's* obligations to you created under the *group* contract. This paragraph will not create any additional obligations whatsoever on the part of *Blue Cross and Blue Shield* other than those obligations created under other provisions of the *group* contract.

Eligibility for Group Coverage

Eligible Employee

An employee is eligible to enroll as a *subscriber* for *group* coverage as long as he or she meets the rules on length of service, active employment, and number of hours worked that the *plan sponsor* has set to determine eligibility for *group* coverage. For details, contact your *plan sponsor*.

Eligible Spouse

The *subscriber* may enroll an eligible spouse for coverage under his or her *group* membership. An "eligible spouse" includes the *subscriber's* legal spouse. A legal civil union spouse, where applicable, is eligible to enroll for coverage under the *subscriber's group* membership to the extent that a legal civil union spouse is determined eligible by the *plan sponsor*. For more details, contact your *plan sponsor*.

Former Spouse

In the event of a divorce or a legal separation, the person who was the spouse of the *subscriber* prior to the divorce or legal separation will remain eligible for coverage under the *subscriber's group* membership, whether or not the judgment was entered prior to the effective date of the *subscriber's group* membership. This coverage is provided with no additional *premium* other than the normal cost of covering a current spouse. The former spouse will remain eligible for this coverage **only** until: the *subscriber* is no longer required by the judgment to provide health care coverage for the former spouse; or the *subscriber* or former spouse remarries, whichever comes first. *Blue Cross and Blue Shield* must be notified within 30 days of a change to the former spouse's address. Otherwise, *Blue Cross and Blue Shield* will not be liable for any acts or omissions due to having the former spouse's incorrect address on file. If the *subscriber* remarries, the former spouse may continue coverage under a separate membership within the *subscriber's group*, provided the divorce judgment requires that the *subscriber* provide health care coverage for the former spouse. This is true even if the *subscriber's* new spouse is not enrolled for coverage under the *subscriber's group* membership.

Domestic Partner
As determined by the *plan sponsor*, the *subscriber* may have the option to enroll an eligible domestic partner (instead of an eligible spouse) under his or her *group* membership. **This eligibility option applies to you only when your Dental Blue Policy includes a domestic partner *rider*. If your Dental Blue Policy does not include a domestic partner *rider*, this section does not apply to you.** A "domestic partner" is a person with whom the *subscriber* has entered into an exclusive relationship. This means that both the *subscriber* and domestic partner: are 18 years of age or older and of legal age of consent in the state where they reside; are competent to enter into a legal contract; share the same residence and must intend to continue to do so; are jointly responsible for basic living costs; are in a relationship of mutual support, caring, and commitment in which they intend to remain; are not married to anyone else; and are not related to each other by adoption or blood to a degree of closeness that would otherwise bar marriage in the state in which they live. A "domestic partner" may also include a person with whom the *subscriber* has registered as a domestic partner with any governmental domestic registry (whether or not all of the conditions stated above have been met). If the *subscriber* enrolls an eligible domestic partner under his or her *group* membership, the domestic partner's dependent children are eligible for coverage to the same extent that the *subscriber's* dependent children are eligible for coverage under his or her *group* membership. If the *subscriber* terminates the domestic partnership, an enrolled former domestic partner (and any enrolled children of a former domestic partner) may have the option to continue *group* coverage to the extent that federal or Massachusetts law would usually apply.

Eligible Dependents
The *subscriber* may enroll eligible dependents for coverage under his or her *group* membership. "Eligible dependents" include the *subscriber's* or spouse's (or if applicable, legal civil union spouse's or domestic partner's) children until the end of the calendar month in which the child turns age 26. To be an eligible dependent, the child is not required to: live with the *subscriber* or spouse (or if applicable, legal civil union spouse or domestic partner); or be a dependent on the *subscriber's* or spouse's (or if applicable, legal civil union spouse's or domestic partner's) tax return; or be a full-time student. These eligible dependents may include:

- A newborn child. The effective date of coverage for a newborn child will be the child's date of birth provided that the *subscriber* formally notifies the *plan sponsor* within 30 days of the date of birth.
- An adopted child. The effective date of coverage for an adopted child will be the date of placement of the child with the *subscriber* for the purpose of adoption. The effective date of coverage for an adoptive child who has been living with the *subscriber* and for whom the *subscriber* has been getting foster care payments will be the date the petition to adopt is filed. If the *subscriber* is enrolled under a family membership as of the date he or she assumes custody of a child for the purpose of adoption, the child's dental benefits will be provided from the date of custody. This coverage is provided without a waiting period or pre-existing condition restriction.
- A newborn infant of an enrolled dependent child immediately from the moment of birth and continuing after, until the enrolled dependent child is no longer eligible as a dependent.

If an eligible dependent child is married, the dependent child can enroll for coverage under the *subscriber's group* membership. And, as long as that enrolled child is an eligible dependent, his or her children are also eligible for coverage under the *subscriber's group* membership. The dependent child's spouse is **not** eligible to enroll as a dependent for coverage under the *subscriber's group* membership.

An eligible dependent may also include:

- A person under age 26 who is not the *subscriber's* or spouse's (or if applicable, legal civil union spouse's or domestic partner's) child but who qualifies as a dependent of the *subscriber* under the Internal Revenue Code. In this case, when the dependent loses his or her dependent status under the Internal Revenue Code, that dependent will continue to be eligible as a dependent under the *subscriber's group* membership for two years after the end of the calendar year in which he or she

last qualified as a dependent under the Internal Revenue Code or until the dependent turns age 26, whichever comes first.
- A child recognized under a Qualified Medical Child Support Order as having the right to enroll for health care coverage.
- A disabled dependent child age 26 or older. A dependent child who is mentally or physically incapable of earning his or her own living and who is enrolled for coverage under the *subscriber's group* membership will continue to be covered after he or she would otherwise lose dependent eligibility under the *subscriber's group* membership, so long as the child continues to be mentally or physically incapable of earning his or her own living. In this case, the *subscriber* must make arrangements with *Blue Cross and Blue Shield* through the *plan sponsor* not more than 30 days after the date the child would normally lose eligibility. Also, *Blue Cross and Blue Shield* must be given any medical or other information that it may need to determine if the child can maintain coverage under the *subscriber's group* membership. From time to time, *Blue Cross and Blue Shield* may conduct reviews that will require a statement from the attending physician. This is to confirm that the child is still an eligible disabled dependent child.

Important Reminder: The eligibility provisions for dependents that are described in this section may differ from the federal tax laws that define who may qualify as a dependent.

Enrollment Periods for Group Coverage

Initial Enrollment

You may enroll for coverage under a *group* membership on your initial *group* eligibility date. This date is determined by your *plan sponsor*. The *plan sponsor* is responsible for providing you with details about how and when you may enroll for coverage under a *group* membership. To enroll, you must complete the enrollment form provided by your *plan sponsor* no later than 30 days after your eligibility date. (For more information, contact your *plan sponsor*.) If you choose not to enroll for coverage under a *group* membership on your initial eligibility date, you may enroll only during your *group's* open enrollment period or within 30 days of a special enrollment event as provided by federal or Massachusetts law.

Special Enrollment

If an eligible employee or an eligible dependent (including the employee's spouse) chooses not to enroll for coverage under a *group* membership on his or her initial *group* eligibility date, federal or Massachusetts law may allow the eligible employee and/or his or her eligible dependents to enroll when:
- The employee and/or his or her eligible dependents have a loss of other coverage (see "Loss of Other Qualified Coverage" below); or
- The employee gains a new eligible dependent (see "New Dependents" below); or
- The employee and/or his or her eligible dependent become eligible for assistance under a Medicaid plan or a state Children's Health Insurance Program plan.

These rights are known as your "special enrollment rights." There may be additional special enrollment rights as a result of changes required by federal law. For example, these changes may include special enrollment rights for: individuals who are newly eligible for coverage as a result of changes to dependent eligibility; and/or individuals who are newly eligible for coverage as a result of the elimination of a lifetime maximum.

Loss of Other Qualified Coverage

An eligible employee may choose not to enroll himself or herself or an eligible dependent (including a spouse) for coverage under a *group* membership on the initial *group* eligibility date because he or she or the eligible dependent has other health plan coverage as defined by federal law. This is referred to as "qualified" coverage. In this case, the employee and the eligible dependent may enroll for coverage under

the *group* membership if the employee or the eligible dependent at a later date loses that other qualified health plan coverage due to any one of the following reasons:

- The employee or the eligible dependents (including a spouse) cease to be eligible for the other qualified health plan. For example, this could mean that the loss of the other qualified health plan was due to: the loss of the spouse's coverage; the death of the spouse; divorce; loss of dependent status; or involuntary termination. This includes when an employee or eligible dependent is covered under a Medicaid plan or a state Children's Health Insurance Program plan and coverage is terminated as a result of loss of eligibility for that coverage.
- The employer that is sponsoring the other qualified group health plan coverage ceases to make employer contributions for the other group health plan coverage.
- The employee or the eligible dependents (including a spouse) exhaust their continuation of group coverage under the other qualified group health plan.
- The prior qualified health plan was terminated due to the insolvency of the health plan carrier.

Important Note: You will **not** have this special enrollment right if the loss of other health plan coverage is a result of the eligible employee or the *subscriber* or the eligible dependent's failure to pay the applicable premiums.

New Dependents
If an eligible employee gains a new spouse or other new eligible dependent(s) due to marriage, adoption, placement for adoption, or birth, the employee and the spouse and/or the new dependent(s) may enroll for coverage under a *group* membership. If the new dependent is gained by birth, adoption, or placement for adoption, enrollment under the *group* membership will be retroactive to the date of birth or the date of adoption or the date of placement for adoption. But, the time requirement described below must be met.

Special Enrollment Time Requirement
To exercise your special enrollment rights, you must notify your *plan sponsor* no later than 30 days after the date when any one of the following events occur: the date you lose your other coverage; the date the *subscriber* gains a new dependent; the date the *subscriber* receives notice that a dependent child who was not previously eligible is newly eligible for coverage as a result of changes to dependent eligibility; or the date you receive notice that you are newly eligible for coverage as a result of the elimination of a lifetime maximum. For example, if your coverage under another health plan is terminated, you must notify your *plan sponsor* and request enrollment within 30 days after your other health care coverage ends. Upon request, the *plan sponsor* will send you any special forms you may need. If you do not request enrollment within 30 days, you will have to wait until the *group's* next open enrollment period to enroll for *group* coverage. You also have special enrollment rights related to termination of coverage under a state Children's Health Insurance Program plan or a Medicaid plan or eligibility for assistance under a Medicaid plan or a state Children's Health Insurance Program plan. When this situation applies, you must notify your *plan sponsor* to request *group* coverage no later than 60 days after the coverage terminates or the employee or eligible dependent is determined to be eligible for assistance.

Qualified Medical Child Support Order
If the *subscriber* chooses not to enroll an eligible dependent for coverage under his or her *group* membership on the initial *group* eligibility date, the *subscriber* may be required by law to enroll the dependent if the *subscriber* is subject to a Qualified Medical Child Support Order (QMCSO). This QMCSO order is a state court or administrative agency order that requires an employer's *group* to provide coverage to the child of an employee who is covered or eligible to enroll for *group* coverage.

Open Enrollment Period
If you choose not to enroll for *group* coverage within 30 days of your initial *group* eligibility date, you may enroll during your *group's* open enrollment period. The open enrollment period is the time each year during

which eligible persons may enroll for or change coverage for the next year. The open enrollment period is announced by the *group* to all eligible employees. To enroll for *group* coverage during this enrollment period, you must complete the enrollment form provided in the *group's* enrollment packet and return it to the *group* no later than the date specified in the *group's* enrollment packet.

Other Membership Changes

Generally, the *subscriber* may make membership changes (for example, change from a *subscriber* only membership to a family membership) only if the *subscriber* has a change in family status. This includes a change such as: marriage or divorce; birth, adoption, or change in custody of a child; death of an enrolled spouse or dependent; or the loss of an enrolled dependent's eligibility under the *subscriber's group* membership. **If you want to ask for a membership change or you need to change your name or mailing address, you should call or write to your *plan sponsor*.** The *plan sponsor* will send you any special forms that you may need. You must request the change within the time period required by the *subscriber's group* to make a change. If you do not make the change within the required time period, you will have to wait until the *group's* next open enrollment period to make the change. All changes are allowed only when they comply with the eligibility and enrollment rules set by the *plan sponsor* for *group* coverage and they comply with the conditions outlined in this Dental Blue Policy and in the *Blue Cross and Blue Shield* Manual of Underwriting Guidelines for Group Business.

Termination of Group Coverage

Loss of Eligibility for Group Coverage

When your eligibility for *group* coverage ends, your *group* coverage will be terminated as of the date you lose eligibility. Your eligibility for *group* coverage ends when:

- The *subscriber* loses eligibility for coverage with the *group*. This means: the *subscriber's* hours are reduced; or the *subscriber* leaves the job; or the *subscriber* no longer meets the rules that are set by the *group* for *group* coverage. You will also lose eligibility for *group* coverage if you are an enrolled dependent when the *subscriber* dies.
- You lose your status as a dependent under the *subscriber's group* membership.
- You reach age 65 and become eligible for Medicare Part A and Part B. However, as allowed by federal law, the *subscriber* and the spouse and/or dependents may have the option of continuing coverage under a *group* membership when the *subscriber* remains as an actively working employee after reaching age 65. You should review all options available to you with the *plan sponsor*. Medicare eligible *subscribers* who retire and/or their spouses are not eligible to continue coverage under a *group* membership once they reach age 65.
- The *plan sponsor* fails to pay the *group premium* to *Blue Cross and Blue Shield* within 30 days of the due date. In this case, *Blue Cross and Blue Shield* will notify you in writing of the termination of your *group* coverage in accordance with the Code of Massachusetts Regulations. This notice will give you information about the termination of your *group* coverage. It will also tell you about your options for coverage offered by *Blue Cross and Blue Shield* or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
- The *group* terminates (or does not renew) its *group* contract with *Blue Cross and Blue Shield*.

Termination of Group Coverage by the Subscriber

Your *group* coverage will end when the *subscriber* chooses to cancel his or her *group* membership as permitted by the *plan sponsor*. *Blue Cross and Blue Shield* must receive the termination request not more than 30 days after the *subscriber's* termination date.

Termination of Group Coverage by Blue Cross and Blue Shield

Your *group* coverage will not be canceled because you are using your benefits or because you will need more *covered services* in the future. *Blue Cross and Blue Shield* will cancel your *group* coverage **only when**:

- You have committed misrepresentation or fraud to *Blue Cross and Blue Shield*. For example, you gave false or misleading information on the enrollment form. Or, you misused your ID card by letting another person who was not enrolled for *group* coverage attempt to get benefits. In this case, the termination of your *group* coverage may go back to your effective date or, it may go back to the date of the misrepresentation or fraud. The termination date will be determined by *Blue Cross and Blue Shield*, subject to applicable federal law. Or, in some cases *Blue Cross and Blue Shield* may limit your benefits.
- You commit acts of physical or verbal abuse that pose a threat to, or a threat to the health of, health care and dental providers or other members or employees of *Blue Cross and Blue Shield* or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc., and these acts are not related to your physical condition or mental condition. In this case, termination of your *group* coverage will follow the procedures approved by the Massachusetts Commissioner of Insurance.
- You fail to comply in a material way with any provisions of this Dental Blue Policy. For example, if you fail to provide information that *Blue Cross and Blue Shield* requests related to your coverage under this Dental Blue Policy, *Blue Cross and Blue Shield* may terminate your *group* coverage.
- *Blue Cross and Blue Shield* discontinues this Dental Blue Policy for any reason as of a date approved by the Massachusetts Commissioner of Insurance.

If *Blue Cross and Blue Shield* cancels your *group* coverage, a notice will be sent to your *group* that will tell your *group* the specific reason(s) that *Blue Cross and Blue Shield* is canceling your *group* coverage.

Continuation of Group Coverage

Limited Extension of Group Coverage under State Law

If you lose eligibility for *group* coverage due to a plant closing or a partial plant closing (as defined by law) in Massachusetts, you may continue *group* coverage as provided by state law. If this happens to you, you and your *group* will each pay your shares of the *premium* cost for up to 90 days after the plant closing. Then, to continue your *group* coverage for up to 39 more weeks, you will pay 100% of the *premium* cost. At this same time, you may also be eligible for continued *group* coverage under other state laws or under federal law (see below). If you are, the starting date for continued *group* coverage under all of these laws will be the same date. But, after the 90-day extension period provided by this state law ends, you may have to pay more *premium* to continue your *group* coverage. If you become eligible for coverage under another employer sponsored health plan at any time before the 39-week extension period ends, continued *group* coverage under these provisions also ends.

Continuation of Group Coverage under Federal or State Law

When you are no longer eligible for *group* coverage, you may be eligible to continue *group* coverage as provided by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or under Massachusetts state law. These provisions apply to you if your *group* has two or more employees. To continue your *group* coverage, you may be required to pay up to 102% of the *premium* cost. These laws apply to you if you lose eligibility for *group* coverage due to one of the following reasons.

- Termination of employment (for reasons other than gross misconduct).
- Reduction of work hours.
- Divorce or legal separation. (In the event of divorce or legal separation, a spouse is eligible to keep coverage under the employee's *group* membership. This is the case only until the employee is no longer required by law to provide health care coverage for the former spouse or the employee or former spouse remarries, whichever comes first. The former spouse's eligibility for continued *group*

coverage will start on the date of divorce, even if he or she continues coverage under the employee's *group* membership. While the former spouse continues coverage under the employee's *group* membership, there is no additional *premium*. After remarriage, under state and federal law, the former spouse may be eligible to continue *group* coverage under a separate *group* membership for an additional *premium* cost.)

- Death of the *subscriber*.
- *Subscriber's* entitlement to Medicare benefits.
- Loss of status as an eligible dependent.

The period of this continued *group* coverage begins with the date of your qualifying event. And, the length of this continued *group* coverage will be up to 36 months from that qualifying event. This is true except for termination of employment or reduction of work hours, in which cases continued *group* coverage is available for only 18 months or, if you are qualified for disability under Title II or Title XVI of the Social Security Act, up to 29 months. (See below for more information about continued coverage for disabled employees.) You should contact your *plan sponsor* for more help about continued coverage.

When a *subscriber's* legal same-sex spouse (or if applicable, civil union spouse or domestic partner) is no longer eligible for coverage under the *subscriber's group* membership, that spouse (or if applicable, that civil union spouse or domestic partner) and his or her dependents may continue coverage in the *subscriber's group* to the same extent that a legal opposite-sex spouse and his or her dependents could continue *group* coverage upon loss of eligibility for *group* coverage.

Additional Continued Group Coverage for Disabled Employees
At the time of the employee's termination of employment or reduction in hours (or within 60 days of the qualifying event under federal law), if an employee or his or her eligible dependent is determined to be disabled under Title II or Title XVI of the Social Security Act, continued *group* coverage will be available for up to 29 months from the date of the qualifying event. The *premium* cost for the additional 11 months may be up to 150% of the *premium* rate. If during these 11 months eligibility for disability is lost, *group* coverage may cancel before the 29 months is completed. You should contact your *plan sponsor* for more help about continued *group* coverage.

Special Rules for Retired Employees
A retired employee, the spouse, and/or eligible dependent children of a retired employee or a surviving spouse of a retired deceased employee who loses eligibility for *group* coverage as a result of a bankruptcy proceeding (Title 11 of the United States Code) is also eligible to continue *group* coverage as provided by COBRA or under Massachusetts state law. A retired employee and/or the surviving spouse of a deceased retired employee may enroll for lifetime continued *group* coverage as of the date of the bankruptcy proceeding, provided that the loss of *group* eligibility occurs within one year before the date on which the bankruptcy proceeding begins. Or, if *group* eligibility is lost within one year after the date on which the bankruptcy proceeding begins, they may enroll for lifetime continued *group* coverage as of the date *group* eligibility is lost. Spouses and/or eligible dependents of these retired employees may enroll for continued *group* coverage until the retired employee dies. Once the retired employee dies, his or her surviving spouse and/or eligible dependents may enroll for up to an additional 36 months of continued *group* coverage beyond the date of the retired employee's death. Lifetime continued *group* coverage for retired employees will end if the *group* cancels its agreement with *Blue Cross and Blue Shield* to provide its *group members* with *group* coverage or for any of the other reasons described below in "Termination of Continued Group Coverage."

Enrollment for Continued Group Coverage
To enroll for continued *group* coverage, you must complete an Election Form. The completed election form must be returned to the office at the address on the form. The form must be returned within 60 days from

your date of termination of *group* coverage or your notification of eligibility, whichever is later. If you do not return the completed form, it will be considered a waiver. And, you will not be allowed to continue *group* coverage. (The 60 days will be counted from the date of the eligibility notice to the postmarked date of the mailed election form.)

Termination of Continued Group Coverage
Your continued *group* coverage will end when:

- The length of time allowed for continued *group* coverage is reached (for example, 18 months or 29 months or 36 months from the qualifying event).
- You fail to make timely payment of your *premium* costs.
- You enroll in another employer sponsored health plan and that plan does not include pre-existing condition limitations or waiting periods.
- You become entitled to Medicare benefits.
- You are no longer disabled (if your continued *group* coverage had been extended because of disability).
- The *group* terminates its agreement with *Blue Cross and Blue Shield* to provide its *group members* with access to dental benefits under this Dental Blue Policy. In this case, *group* coverage may continue under another health plan. Contact your *plan sponsor* for more information.

Part 7
Individual Policy

This Part 7 applies to you when you are enrolled as a direct pay *member* under this Dental Blue Policy, and not as a *group member*. As a direct pay *member*, the *subscriber* has an agreement (a contract) with *Blue Cross and Blue Shield* to provide the *subscriber* and his or her enrolled eligible spouse and other enrolled eligible dependents with access to the dental benefits described in this Dental Blue Policy. The *subscriber* must pay a monthly *premium* to *Blue Cross and Blue Shield* for this coverage.

You hereby expressly acknowledge your understanding that this contract constitutes a contract solely between you and Blue Cross and Blue Shield of Massachusetts, Inc. (*Blue Cross and Blue Shield*), which is an corporation independent of and operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting *Blue Cross and Blue Shield* to use the Blue Cross and Blue Shield Service Marks in the Commonwealth of Massachusetts, and that *Blue Cross and Blue Shield* is not contracting as the agent of the Association. You further acknowledge and agree that you have not entered into this contract based upon representations by any person other than *Blue Cross and Blue Shield* and that no person, entity, or organization other than *Blue Cross and Blue Shield* will be held accountable or liable to you for any of *Blue Cross and Blue Shield's* obligations to you created under this contract. This paragraph will not create any additional obligations whatsoever on the part of *Blue Cross and Blue Shield* other than those obligations created under other provisions of this contract.

Eligibility for Individual Coverage

Eligible Individual

You are eligible to enroll as a *subscriber* for direct pay coverage as long as you are a resident of Massachusetts. A "resident" is a person who lives in Massachusetts as shown by evidence that is considered acceptable by *Blue Cross and Blue Shield*. This means *Blue Cross and Blue Shield* may ask you for evidence such as a lease or rental agreement, a mortgage bill, or a utility bill. The fact that you are in a nursing home, a hospital, or other institution does not by itself mean you are a resident. And, you are not a resident if you come to Massachusetts to receive medical care or to attend school but you still have residency outside of Massachusetts.

If the eligible individual who is requesting to enroll as a direct pay *subscriber* is under age 18, the enrollment form must be completed by the parent or guardian. In this case, the person who is executing the direct pay contract is not eligible for benefits under the direct pay membership. But, he or she will be responsible for acting on behalf of the *subscriber* as necessary and pay the monthly *premium* as described in this Dental Blue Policy. The person who executes the direct pay contract will be considered the *subscriber's* authorized representative.

Eligible Spouse

The *subscriber* may enroll an eligible spouse for coverage under his or her direct pay membership. An "eligible spouse" includes the *subscriber's* legal spouse or legal civil union spouse. An eligible spouse must also meet all of the same eligibility conditions as described above for an eligible individual.

Former Spouse

In the event of a divorce or a legal separation, the person who was the spouse of the *subscriber* prior to the divorce or legal separation may maintain coverage under the *subscriber's* direct pay membership. This coverage may continue **only** until: the *subscriber* is no longer required by the divorce judgment to provide health care coverage for the former spouse; or the *subscriber* or former spouse remarries, whichever comes first. In either case, the former spouse may wish to enroll as a *subscriber* under his or her own direct pay membership. The *Blue Cross and Blue Shield* customer service office can help you with these options. *Blue*

Cross and Blue Shield must be notified within 30 days of a change to the former spouse's address. Otherwise, *Blue Cross and Blue Shield* will not be liable for any acts or omissions due to having the former spouse's incorrect address on file.

Domestic Partner

The *subscriber* may have the option to enroll an eligible domestic partner (instead of an eligible spouse) for coverage under his or her direct pay membership. **This eligibility option applies only when your Dental Blue Policy includes a domestic partner *rider*. If your Dental Blue Policy does not include a domestic partner *rider*, this section does not apply to you.** A "domestic partner" is a person with whom the *subscriber* has entered into an exclusive relationship. This means that both the *subscriber* and domestic partner: are 18 years of age or older and of legal age of consent in the state where they reside; are competent to enter into a legal contract; share the same residence and must intend to continue to do so; are jointly responsible for basic living costs; are in a relationship of mutual support, caring, and commitment in which they intend to remain; are not married to anyone else; and are not related to each other by adoption or blood to a degree of closeness that would otherwise bar marriage in the state in which they live. A "domestic partner" may also include a person with whom the *subscriber* has registered as a domestic partner with any governmental domestic registry (whether or not all of the conditions stated above have been met). If the *subscriber* enrolls an eligible domestic partner under his or her direct pay membership, the domestic partner's dependent children are eligible for coverage to the same extent that the *subscriber's* dependent children are eligible for coverage under his or her direct pay membership.

Eligible Dependents

The *subscriber* may enroll eligible dependents for coverage under his or her direct pay membership. Eligible dependents must meet all of the same eligibility conditions as described above for an eligible individual. However, a dependent child may live outside of Massachusetts to attend school as long as he or she has not moved out of Massachusetts permanently. "Eligible dependents" include the *subscriber's* or spouse's (or if applicable, legal civil union spouse's or domestic partner's) children until the end of the calendar month in which the child turns age 26. To be an eligible dependent, the child is not required to: live with the *subscriber* or spouse (or if applicable, legal civil union spouse or domestic partner); or be a dependent on the *subscriber's* or spouse's (or if applicable, legal civil union spouse's or domestic partner's) tax return; or be a full-time student. These eligible dependents may include:

- A newborn child. The effective date of coverage for a newborn child will be the child's date of birth provided that the *subscriber* formally notifies *Blue Cross and Blue Shield* within 30 days of the date of birth.
- An adopted child. The effective date of coverage for an adopted child will be the date of placement of the child with the *subscriber* for the purpose of adoption. The effective date of coverage for an adoptive child who has been living with the *subscriber* and for whom the *subscriber* has been getting foster care payments will be the date the petition to adopt is filed. If the *subscriber* is enrolled under a family membership as of the date he or she assumes custody of a child for the purpose of adoption, the child's dental benefits will be provided from the date of custody. This coverage is provided without a waiting period or pre-existing condition restriction.
- A newborn infant of an enrolled dependent child immediately from the moment of birth and continuing after, until the enrolled dependent child is no longer eligible as a dependent.

If an eligible dependent child is married, the dependent child can enroll for coverage under the *subscriber's* direct pay membership. And, as long as that enrolled child is an eligible dependent, his or her children are also eligible for coverage under the *subscriber's* direct pay membership. The dependent child's spouse is **not** eligible to enroll as a dependent for coverage under the *subscriber's* direct pay membership.

An eligible dependent may also include:

- A person under age 26 who is not the *subscriber's* or spouse's (or if applicable, legal civil union spouse's or domestic partner's) child but who qualifies as a dependent of the *subscriber* under the Internal Revenue Code. In this case, when the dependent loses his or her dependent status under the Internal Revenue Code, that dependent will continue to be eligible as a dependent under the *subscriber's* direct pay membership for two years after the end of the calendar year in which he or she last qualified as a dependent under the Internal Revenue Code or until the dependent turns age 26, whichever comes first.
- A child recognized under a Qualified Medical Child Support Order as having the right to enroll for health care coverage.
- A disabled dependent child age 26 or older. A dependent child who is mentally or physically incapable of earning his or her own living and who is enrolled for coverage under the *subscriber's* direct pay membership will continue to be covered after he or she would otherwise lose dependent eligibility under the *subscriber's* direct pay membership, so long as the child continues to be mentally or physically incapable of earning his or her own living. In this case, the *subscriber* must make arrangements with *Blue Cross and Blue Shield* not more than 30 days after the date the child would normally lose eligibility. Also, *Blue Cross and Blue Shield* must be given any medical or other information that it may need to determine if the child can maintain coverage under the *subscriber's* direct pay membership. From time to time, *Blue Cross and Blue Shield* may conduct reviews that will require a statement from the attending physician. This is to confirm that the child is still an eligible disabled dependent child.

Important Reminder: The eligibility provisions for dependents that are described in this section may differ from the federal tax laws that define who may qualify as a dependent.

Enrolling for Individual Coverage

Open Enrollment Period

If you are an eligible individual, you can enroll for coverage under a direct pay membership only during a designated open enrollment period, except when any of the special enrollment situations as described below apply to you. For information about open enrollment periods and when they occur, you may contact the *Blue Cross and Blue Shield* customer service office.

Special Enrollment

If any one of the following special enrollment situations applies, you may enroll for coverage under a direct pay membership, without waiting for a designated open enrollment period. In any of these situations, you will be enrolled within 30 days of the date that *Blue Cross and Blue Shield* receives your completed enrollment form.

- You had prior creditable health coverage. *Blue Cross and Blue Shield* must receive your enrollment request within 63 days of the termination date of your prior health coverage.
- You have a qualifying event, including (but are not limited to): marriage; birth or adoption of a child; court-ordered care of a child; loss of coverage as a dependent under a group or government health plan; or any other event as may be designated by the Commissioner of Insurance. *Blue Cross and Blue Shield* must receive your enrollment request within 63 days of the event or within 30 days of the event if coverage is for an eligible dependent.
- You have been granted a waiver by the Office of Patient Protection to enroll outside of the open enrollment period.

Enrollment Process

To apply for coverage under a direct pay membership, you must complete an enrollment application and send it to *Blue Cross and Blue Shield*. You must also send any other documentation or statements that *Blue Cross and Blue Shield* may ask that you send in order for *Blue Cross and Blue Shield* to verify that you are

eligible to enroll under a direct pay membership. You must make sure that all of the information that you include on these forms is true, correct, and complete. Your right to coverage under a direct pay membership is based on the condition that all information that you provide to *Blue Cross and Blue Shield* is true, correct, and complete.

During the enrollment process, *Blue Cross and Blue Shield* will check and verify each person's eligibility for coverage under a direct pay membership. This means that when you apply for coverage, you may be required to provide evidence that you are a resident of Massachusetts. Examples of evidence to show that you are a resident can be a copy of your lease or rental agreement, a mortgage bill, or a utility bill. If you are not a citizen of the United States, *Blue Cross and Blue Shield* may also require that you provide official U.S. immigration documentation. You will also be asked to provide information about your prior health plan(s), and you may be required to provide a copy of your certificate(s) of health plan coverage. If you fail to provide information to *Blue Cross and Blue Shield* that it needs to verify your eligibility for a direct pay membership, *Blue Cross and Blue Shield* will deny your enrollment request. Once you are enrolled under a direct pay membership, each year prior to your renewal date, *Blue Cross and Blue Shield* may check and verify that you are still eligible for coverage under a direct pay membership.

Blue Cross and Blue Shield may deny your enrollment for coverage, or cancel your coverage, under a direct pay membership for any of the following reasons:

- You fail to provide information to *Blue Cross and Blue Shield* that it needs to verify your eligibility for coverage under a direct pay membership.
- You committed misrepresentation or fraud to *Blue Cross and Blue Shield* about your eligibility for coverage under a direct pay membership.
- You made at least three or more late payments for your health care plan(s) in a 12-month period.
- You voluntarily ended your coverage under a direct pay membership within the past 12 months on a date that is not your renewal date. But, this does not apply if you had creditable coverage (as defined by state law) continuously up to a date not more than 63 days prior to the date of your request for enrollment under a direct pay membership.

If your enrollment request is denied or your coverage is canceled, *Blue Cross and Blue Shield* will send you a letter that will tell you the specific reason(s) for which they have denied (or canceled) your coverage under a direct pay membership. This information will be made available, upon request, to the Massachusetts Commissioner of Insurance.

Membership Changes

Generally, the *subscriber* may make changes (for example, change from a membership that covers only one person to a family membership) only if the *subscriber* has a change in family status. This includes a change such as: marriage or divorce; birth, adoption or change in custody of a child; death of an enrolled spouse or dependent; or the loss of an enrolled dependent's eligibility under the *subscriber's* direct pay Dental Blue Policy. If you want to ask for a membership change or you need to change your name or mailing address, you should call or write to *Blue Cross and Blue Shield. Blue Cross and Blue Shield* will send you any forms that you may need. You must request a membership change within 30 days of the reason for the change. Or, if the newly eligible person had prior creditable coverage (as defined by state law), the change must be requested within 63 days of the termination date of the prior health care coverage. If you do not request the change within the time required, you will have to wait until the next designated open enrollment period to make the change. All changes are allowed only when they comply with the conditions outlined in the Dental Blue Policy and with *Blue Cross and Blue Shield* policies.

Termination of Individual Coverage

Loss of Eligibility for Direct Pay Coverage

When your eligibility for direct pay coverage ends, your direct pay coverage will be terminated as of the date you lose eligibility. Your eligibility for direct pay coverage ends when:

- You lose your status as an eligible dependent under the *subscriber's* direct pay membership.
- You move out of Massachusetts.

Each year prior to your renewal date, *Blue Cross and Blue Shield* may ask you for information to verify that you are still eligible for coverage under a direct pay membership. If you are no longer eligible for direct pay coverage or you do not provide the requested information, your coverage will be canceled as of your renewal date. *Blue Cross and Blue Shield* will send you a letter that will tell you the specific reason(s) for which your coverage under the direct pay membership is canceled.

Termination of Direct Pay Coverage by the Subscriber

Your direct pay coverage will end when:

- The *subscriber* chooses to cancel his or her direct pay membership. To do this, the *subscriber* must send a written request to *Blue Cross and Blue Shield*. The termination date will be effective 15 days after the date that *Blue Cross and Blue Shield* receives the termination request. Or, the *subscriber* may ask for a specific termination date. In this case, *Blue Cross and Blue Shield* must receive the request at least 15 days before that requested termination date. *Blue Cross and Blue Shield* will return to the *subscriber* any *premiums* that are paid for a time after the termination date.
- The *subscriber* fails to pay his or her *premium* to *Blue Cross and Blue Shield* within 35 days after it is due. If *Blue Cross and Blue Shield* does not get the full *premium* on or before the due date, *Blue Cross and Blue Shield* will stop claim payments as of the last date through which the *premium* is paid. Then, if *Blue Cross and Blue Shield* does not get the full *premium* within this required time period, *Blue Cross and Blue Shield* will cancel your direct pay coverage. The termination date will be the last date through which the *premium* is paid.

Termination of Direct Pay Coverage by Blue Cross and Blue Shield

Your direct pay coverage will not be canceled because you are using your benefits or because you will need more *covered services* in the future. *Blue Cross and Blue Shield* will cancel your direct pay coverage **only when**:

- You have committed misrepresentation or fraud to *Blue Cross and Blue Shield*. For example, you gave false or misleading information on the enrollment form. Or, you misused your ID card by letting another person who was not enrolled for coverage attempt to get benefits. In this case, the termination of your direct pay Dental Blue Policy may go back to your effective date or, it may go back to the date of the misrepresentation or fraud. The termination date will be determined by *Blue Cross and Blue Shield*. Or, in some cases *Blue Cross and Blue Shield* may limit your benefits.
- You commit acts of physical or verbal abuse that pose a threat to, or a threat to the health of, health care and dental providers or other members or employees of *Blue Cross and Blue Shield* or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc., and these acts are not related to your physical condition or mental condition. In this case, this termination will follow the procedures approved by the Massachusetts Commissioner of Insurance.
- You fail to comply in a material way with any provision of this Dental Blue Policy. For example, if you fail to provide information that *Blue Cross and Blue Shield* requests related to your coverage under this Dental Blue Policy, *Blue Cross and Blue Shield* may terminate your coverage.
- *Blue Cross and Blue Shield* discontinues this Dental Blue Policy. *Blue Cross and Blue Shield* may discontinue this Dental Blue Policy for any reason as of a date approved by the Massachusetts Commissioner of Insurance.

In the event that *Blue Cross and Blue Shield* cancels your coverage, a notice will be sent to you that will tell you the specific reason(s) that *Blue Cross and Blue Shield* is canceling your direct pay coverage.

Part 8

Explanation of Terms

The following words are shown in italics in this Dental Blue Policy, your *Schedule of Dental Benefits*, and any *riders* that apply to your benefits under this Dental Blue Policy. The meaning of these words will help you understand your dental benefits.

Allowed Charge (Allowed Amount)

The maximum reimbursement amount for a specific *covered service* that is used to calculate your cost-sharing amounts and payment of your dental benefits. It is the dollar amount assigned for a *covered service* based on various pricing mechanisms. In most cases when you use a *participating dentist* for *covered services*, you do not have to pay the amount of the *participating dentist's* actual charge that is in excess of the ***allowed charge***. But when you use a non-*participating dentist* for *covered services*, you will have to pay the amount of the dentist's actual charge that is in excess of the ***allowed charge*****. This amount is in addition to your cost-sharing amounts.** (See "How Your Benefits Are Calculated" in Part 1.)

Balance Billing

There may be certain times when a dentist will bill you for the difference between his or her charge and the *allowed charge*. This is called *balance billing*. In most cases, a *participating dentist* cannot *balance bill* you for *covered services*. (See "How Your Benefits Are Calculated" in Part 1.) A non-*participating dentist* can *balance bill* you for costs that are in excess of the ***allowed charge***. **This *balance bill* is in addition to your cost-sharing amounts.**

Blue Cross and Blue Shield

Blue Cross and Blue Shield of Massachusetts, Inc. This includes an employee or designee of *Blue Cross and Blue Shield* who is authorized to make decisions or take action called for under this Dental Blue Policy. *Blue Cross and Blue Shield* has full discretionary authority to interpret this Dental Blue Policy. This includes determining the amount, form, and timing of benefits, conducting reviews to determine whether your dental care is *necessary and appropriate*, and resolving any other matters regarding your right to benefits for *covered services* as described in this Dental Blue Policy. All determinations by *Blue Cross and Blue Shield* with respect to benefits under this Dental Blue Policy will be conclusive and binding unless it can be shown that the interpretation or determination was arbitrary and capricious.

Coinsurance

The cost you may have to pay for a *covered service* (your cost-sharing amount). A *coinsurance* will be calculated as a percentage (for example, 20%). When a *coinsurance* applies to a specific *covered service*, your cost-sharing amount will be calculated based on the *allowed charge* or the dentist's actual charge if it is less than the *allowed charge*. Your *Schedule of Dental Benefits* shows your cost-sharing amounts.

Copayment

The cost you may have to pay for a *covered service* (your cost-sharing amount). A *copayment* is a fixed dollar amount. In most cases, a *participating dentist* will collect the *copayment* from you at the time the *covered service* is furnished. But, when the dentist's actual charge at the time of furnishing the *covered service* is less than your *copayment*, you pay only the dentist's actual charge. Any later charge adjustment—up or down—will not affect your *copayment* or the cost you were charged at the time of the service if it was less than the *copayment*. Your *Schedule of Dental Benefits* shows your cost-sharing amounts.

Covered Services

The dental care covered by this Dental Blue Policy and for which *Blue Cross and Blue Shield* will provide benefits. To be a *covered service* for benefits, each of the following conditions must be met:

- It must be listed as a *covered service* in this Dental Blue Policy; and
- The person who had the service must be a *member* who is eligible for these dental benefits; and
- The service is *necessary and appropriate* as determined by *Blue Cross and Blue Shield*; and
- The service conforms to *Blue Cross and Blue Shield* dental guidelines and *utilization review*; and
- The service is furnished by a *participating dentist* (except as noted in Part 1).

Deductible

The cost you may have to pay for certain *covered services* before you receive dental benefits under this Dental Blue Policy. A *deductible* is calculated based on the *allowed charge* or the dentist's actual charge if it is less than the *allowed charge*. Your *Schedule of Dental Benefits* shows the amount of your *deductible*, if there is one. It also shows the *covered services* for which the *deductible* must be paid before you will receive dental benefits. There are some costs you pay that do not count toward the *deductible*. These costs that do **not** count are:

- The *copayments* and/or *coinsurance* you pay.
- The costs you pay for your Dental Blue Policy.
- The costs you pay that are more than the *allowed charge* (*balance billing*).
- The costs you pay when your benefits are reduced or denied because you did not follow the requirements of your Dental Blue Policy.

How a Family Deductible Is Calculated

When a family *deductible* applies to your dental benefits, the family *deductible* can be met by eligible costs incurred by any combination of family *members* that are covered under the same membership. But, no one *member* will have to pay more than the "per *member*" *deductible* amount.

Group

The corporation, partnership, individual proprietorship, or other organization that has an agreement for *Blue Cross and Blue Shield* to provide its enrolled *group members* with access to dental benefits as described in this Dental Blue Policy. The group should deliver to its *group members* notices from *Blue Cross and Blue Shield*. The *group* is your agent and is not the agent of *Blue Cross and Blue Shield*.

Member

A person who is enrolled and eligible for coverage under this Dental Blue Policy. A *member* may be the *subscriber* or his or her enrolled eligible spouse or any other enrolled eligible dependent.

Necessary and Appropriate

Covered services must meet *Blue Cross and Blue Shield necessary and appropriate* criteria for coverage. *Blue Cross and Blue Shield* has the discretion to determine whether your dental care is *necessary and appropriate* for you. It will do this by referring to the following criteria:

- The dental service must be consistent with the prevention and treatment of oral disease or with the diagnosis and treatment of teeth that are decayed or fractured, or where the supporting structure is weakened by disease;
- The dental service must be furnished in accordance with standards of good dental practice; and
- The dental service is not solely for your convenience or the convenience of your dentist.

In some cases, *Blue Cross and Blue Shield* may review dental records describing your condition and treatment. *Blue Cross and Blue Shield* staff, including dental consultants, will review the treatment plan

objectively and determine whether coverage is available under this Dental Blue Policy, and whether these services are *necessary and appropriate* for you. Based on *Blue Cross and Blue Shield's* findings, *Blue Cross and Blue Shield* may determine that a service is not *necessary and appropriate* for you, even if your dentist has recommended, approved, prescribed, ordered, or furnished the service.

Out-of-Pocket Maximum (Out-of-Pocket Limit)

The maximum cost-sharing amount that you will have to pay for certain *covered services*. Your *Schedule of Dental Benefits* will show the amount of your *out-of-pocket maximum* and the time frame for which it applies—such as each calendar year or each *plan year*. It will also describe the cost-sharing amounts you pay that will count toward the *out-of-pocket maximum*. Once the cost-sharing amounts that count toward the *out-of-pocket maximum* add up to the *out-of-pocket maximum* amount, you will receive full benefits based on the *allowed charge* for more of these *covered services* during the rest of the time frame in which the *out-of-pocket maximum* provision applies. There are some costs you pay that do not count toward the *out-of-pocket maximum*. These costs that do **not** count toward the *out-of-pocket maximum* are:

- The costs you pay for your Dental Blue Policy.
- The costs you pay that are more than the *allowed charge* (*balance billing*).
- The costs you pay when your benefits are reduced or denied because you did not follow the requirements of this Dental Blue Policy.

How a Family Out-of-Pocket Maximum Is Calculated

When a family *out-of-pocket maximum* applies for your dental benefits, the family *out-of-pocket maximum* can be met by eligible cost-sharing amounts paid for any combination of family *members* that are covered under the same membership. But, no one *member* will have to pay more than the "per *member*" *out-of-pocket maximum* amount.

Participating Dentist

A dentist or dental provider group that has a written payment agreement with, or has been designated by, *Blue Cross and Blue Shield* to provide dental services to *members* enrolled under this Dental Blue Policy. This includes a hygienist employed by a *participating dentist*.

Plan Sponsor

When you are enrolled as a *group member*, the *plan sponsor* is usually your employer and is the same as the plan sponsor designated under the Employee Retirement Income Security Act of 1974, as amended (ERISA). If you are not sure who your *plan sponsor* is, you should ask the *subscriber's* employer.

Plan Year

The period of time that may be used to calculate your *deductible* and *out-of-pocket maximum* amounts. It starts on your original effective date of coverage under this Dental Blue Policy and continues for 12 consecutive months or until your next annual renewal date (or when you are a *group member*, your *group's* next annual renewal date), whichever comes first. A new *plan year* begins each 12-month period on your renewal date. If you do not know when your *plan year* begins, you can ask *Blue Cross and Blue Shield* or, if you are a *group member*, your *plan sponsor*. Your *Schedule of Dental Benefits* shows the time frame for which the *deductible* and *out-of-pocket maximum* applies (for example, each *plan year* or each calendar year).

Premium

The monthly cost of your coverage. Your monthly *premium* will be provided to you in the yearly evidence of coverage packet that is issued by *Blue Cross and Blue Shield*. To receive the benefits described in this

Dental Blue Policy, the *premium* owed for your coverage must be paid to *Blue Cross and Blue Shield*. Your *premium* may change from time to time. Each time *Blue Cross and Blue Shield* changes your *premium*, *Blue Cross and Blue Shield* will notify you or, when you are enrolled as a *group member*, the *subscriber's group* on your behalf before the change takes place.

Rider

Blue Cross and Blue Shield or, when you are enrolled as a *group member*, your *group* may change the terms of your Dental Blue Policy. If a material change is made to your Dental Blue Policy, it is described in a *rider*. For example, a *rider* may add to or limit the benefits provided by your Dental Blue Policy. *Blue Cross and Blue Shield* will supply you with *riders* (if there are any) that apply to your dental benefits. You should keep these *riders* with this Dental Blue Policy and your *Schedule of Dental Benefits* so that you can refer to them.

Schedule of Dental Benefits

This Dental Blue Policy includes a *Schedule of Dental Benefits*. It describes the cost-sharing amounts you must pay for each *covered service* (such as a *deductible*, or a *copayment*, or a *coinsurance*). And, it includes important information about your *deductible* and your *out-of-pocket maximum*. It also describes the benefit limits that apply for certain *covered services*. **Be sure to read all parts of this Dental Blue Policy and your *Schedule of Dental Benefits* so you can understand your dental benefits.** You should be sure to read the descriptions of *covered services* and exclusions that are described in Part 1 of this Dental Blue Policy and in your *Schedule of Dental Benefits*.

Subscriber

The eligible person who signs the enrollment form at the time of enrollment for coverage.

Utilization Review

The review process that *Blue Cross and Blue Shield* uses to evaluate the *necessity and appropriateness* of a dental service. To do this, *Blue Cross and Blue Shield* uses clinical guidelines and *utilization review* criteria that are designed to monitor the use of, or evaluate the clinical necessity and appropriateness of the service. This process is designed to encourage appropriate care, not less care. To develop its clinical guidelines and *utilization review* criteria, *Blue Cross and Blue Shield* assesses each service to determine that it is: consistent with the prevention and treatment of tooth decay and other forms of oral disease, or with the treatment of teeth that are decayed or fractured or where the supporting structure is weakened by disease; consistent with standards of good dental practice; and as cost effective as any established alternative. Periodically, *Blue Cross and Blue Shield* reviews its policies, clinical guidelines, and review criteria to reflect new treatments, applications, and technologies.

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Dental Blue Policy
BCBS-DENT (1-1-2014)

Student Health Policy

You are enrolled in the student health plan sponsored by the institution of higher education (the *group*) that has entered into an agreement (a *group* "contract") with Blue Cross and Blue Shield of Massachusetts, Inc. to provide health care benefits to eligible students and their eligible dependents. Your *plan sponsor* is the institution of higher education.

You hereby expressly acknowledge your understanding that the *group* contract constitutes a contract solely between your *group* on your behalf and Blue Cross and Blue Shield of Massachusetts, Inc., which is a corporation independent of and operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting *Blue Cross and Blue Shield* to use the Blue Cross and Blue Shield Service Marks in the Commonwealth of Massachusetts, and that *Blue Cross and Blue Shield* is not contracting as the agent of the Association. You further acknowledge and agree that your *group* on your behalf has not entered into the *group* contract based upon representations by any person other than *Blue Cross and Blue Shield* and that no person, entity, or organization other than *Blue Cross and Blue Shield* will be held accountable or liable to you or your *group* on your behalf for any of *Blue Cross and Blue Shield's* obligations to you created under the *group* contract. This paragraph will not create any additional obligations whatsoever on the part of *Blue Cross and Blue Shield* other than those obligations created under other provisions of the *group* contract.

Eligibility and Enrollment for Student Health Plan Coverage

Eligible Student

You are eligible for coverage under the *group's* student health plan as long as you are a student enrolled in a certificate, diploma, or degree-granting program through the *group* and you are either:

- A full-time student who meets the minimum academic requirements for full-time students set by the *group*; or
- A part-time student who participates in at least 75% of the academic requirements for full-time students.

Automatic Enrollment

An eligible student will be automatically enrolled in the *group's* student health plan by the *group*. The *group* may allow an eligible student to waive enrollment in the *group's* student health plan if he or she has coverage in another health plan that is comparable to the coverage that is required by law for a student health plan. For enrollment information or details about waiving coverage in the *group's* student health plan, you must contact the *group*. You must also contact the *group* if you would like to request the *group's* written policy regarding partial year student enrollment.

Premium Payments

For coverage in the *group's* student health plan, the *group* will include the enrolled student's total *premium* amount in the student's tuition bill. Then each month, the *group* will pay the monthly *premium* amount to *Blue Cross and Blue Shield* for your coverage in the *group's* student health plan. For more

information about your *premium* or if you would like to request the *group's* written policy regarding *premium* refunds, you must contact the *group*.

Eligible Spouse

An eligible student who is enrolled in the *group's* student health plan may enroll an eligible spouse for coverage under his or her student health plan membership. An "eligible spouse" includes the enrolled student's legal spouse. (A legal civil union spouse, where applicable, is eligible to enroll under the student's student health plan membership to the extent that a legal civil union spouse is determined eligible by the *group*. For more details, contact your *plan sponsor*.)

Former Spouse

In the event of a divorce or a legal separation, the person who was the spouse of the enrolled student prior to the divorce or legal separation will remain eligible for coverage under the enrolled student's student health plan membership, whether or not the judgment was entered prior to the *effective date* of the enrolled student's student health plan membership. This coverage is provided with no additional *premium* other than the normal cost of covering a current spouse. The former spouse will remain eligible for this coverage **only** until the enrolled student is no longer required by the judgment to provide health insurance for the former spouse or the enrolled student or former spouse remarries, whichever comes first. In these situations, *Blue Cross and Blue Shield* must be notified within 30 days of a change to the enrolled student's former spouse's address. Otherwise, *Blue Cross and Blue Shield* will not be liable for any acts or omissions due to having the enrolled student's former spouse's incorrect address on file. If the enrolled student remarries, the former spouse may continue coverage under a separate student health plan membership with the *group*, provided the divorce judgment requires that the enrolled student provide health insurance for the former spouse. This is true even if the enrolled student's new spouse is not enrolled under the enrolled student's student health plan membership.

Domestic Partner

As determined by the *group*, an enrolled student may have the option to enroll an eligible domestic partner (instead of an eligible spouse) under his or her student health plan membership. (If the *group's* student health plan does not include a domestic partner *rider*, this section does not apply to you.) A "domestic partner" is a person with whom the enrolled student has entered into an exclusive relationship. This means that both the enrolled student and domestic partner: are 18 years of age or older and of legal age of consent in the state where they reside; are competent to enter into a legal contract; share the same residence and must intend to continue to do so; are jointly responsible for basic living costs; are in a relationship of mutual support, caring, and commitment in which they intend to remain; are not married to anyone else; and are not related to each other by adoption or blood to a degree of closeness that would otherwise bar marriage in the state in which they live. A "domestic partner" may also include a person with whom the enrolled student has registered as a domestic partner with any governmental domestic registry (whether or not all of the conditions stated above have been met). If the enrolled student enrolls an eligible domestic partner under his or her student health plan membership, the domestic partner's dependent children are eligible for coverage to the same extent that the enrolled student's dependent children are eligible for coverage under his or her student health plan membership. If the enrolled student terminates the domestic partnership, the former domestic partner and any children of a former domestic partner are no longer eligible for coverage.

Eligible Dependents

An eligible student who is enrolled in the *group's* student health plan may enroll eligible dependents under his or her student health plan membership. "Eligible dependents" include the enrolled student's (or his or her spouse's or, if applicable, domestic partner's) children who are under age 26. To be an eligible dependent, a child under age 26 is not required to live with the enrolled student or the enrolled student's spouse (or domestic partner), be a dependent on the enrolled student's or the spouse's (or domestic partner's) tax return, or be a full-time student. These eligible dependents may include:

- A newborn child. The *effective date* of coverage for a newborn child will be the child's date of birth provided that the enrolled student formally notifies the *group* within 30 days of the date of birth. (A claim for the enrolled mother's maternity admission may be considered to be this notice when the enrolled student's coverage is a family plan.) The group's student health plan provides coverage for newborn infants for injury and sickness. This includes the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth. The coverage for these services is subject to all of the provisions of the *group's* student health plan.
- An adopted child. The *effective date* of coverage for an adopted child will be the date of placement with the enrolled student for the purpose of adoption. The *effective date* of coverage for an adoptive child who has been living with the enrolled student and for whom the enrolled student has been getting foster care payments will be the date the petition to adopt is filed. If the enrolled student is enrolled under a family plan as of the date he or she assumes custody of a child for the purpose of adoption, the child's health care services for injury or sickness will be covered from the date of custody. (This coverage is provided without a waiting period or pre-existing condition restriction.) This includes the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities and premature birth. The coverage for these services is subject to all of the provisions of the *group's* student health plan.
- A newborn infant of an enrolled dependent child immediately from the moment of birth and continuing after, until the enrolled dependent child is no longer eligible as a dependent.

If an eligible dependent child is married, the dependent child can enroll for coverage under the enrolled student's membership. And, as long as that enrolled child is an eligible dependent, his or her children are also eligible for coverage under the enrolled student's membership. The dependent child's spouse is **not** eligible to enroll as a dependent for coverage under the enrolled student's membership.

An eligible dependent may also include:

- A person under age 26 who is not the enrolled student's (or the student's spouse's or, if applicable, domestic partner's) child but who qualifies as a dependent of the enrolled student under the Internal Revenue Code. When the dependent loses his or her dependent status under the Internal Revenue Code, that dependent will continue to be eligible as a dependent for coverage in the *group's* student health plan under the enrolled student's membership for two years after the end of the calendar year in which he or she last qualified as a dependent under the Internal Revenue Code or until the dependent turns age 26, whichever comes first.
- A child recognized under a Medical Child Support Order as having the right to enroll for health care coverage.
- A disabled dependent child age 26 or older. A dependent child who is mentally or physically incapable of earning his or her own living and who is enrolled under the enrolled student's membership will continue to be covered after he or she would otherwise lose dependent eligibility for coverage under the enrolled student's membership, so long as the child continues to be mentally or physically incapable of earning his or her own living. In this case, the enrolled student must make arrangements with *Blue Cross and Blue Shield* not more than 30 days after the date the child would normally lose eligibility. Also, *Blue Cross and Blue Shield* must be given any medical or other

information that it may need to determine if the child can maintain coverage in the *group's* student health plan under the enrolled student's membership. From time to time, *Blue Cross and Blue Shield* may conduct reviews that will require a statement from the attending physician. This is to confirm that the child is still an eligible disabled dependent child.

Important Reminder:	The eligibility provisions for dependents that are described in this section may differ from the federal tax laws that define who may qualify as a dependent.

Membership Changes

Generally, the enrolled student may make membership changes (for example, change from a student-only plan to a family plan) only if he or she has a change in family status. This includes a change such as: marriage or divorce; birth, adoption or change in custody of a child; death of an enrolled spouse or dependent; or the loss of an enrolled dependent's eligibility under the enrolled student's student health plan membership. **If you want to ask for a membership change or you need to change your name or mailing address, you should call or write to your *plan sponsor*.** The *plan sponsor* will send you any special forms you may need. You must request the change within the time period required by the *group* to make a change. All changes are allowed only when they comply with the eligibility and enrollment rules set by the *plan sponsor* for the *group's* student health plan and they must also comply with applicable laws and regulations.

Termination of Coverage

When your eligibility for the *group's* student health plan ends, your coverage in this dental plan will be terminated as of the date you lose eligibility. Your eligibility ends when:

- You are no longer an "eligible student" as determined by the *group*. In the event that a spouse and/or dependents are enrolled under the student's membership, their coverage will also be terminated as of the date the student loses eligibility for coverage in the *group's* student health plan. The coverage for the student's enrolled spouse and/or dependents will also be terminated in the event the enrolled student dies.
- You are enrolled as a dependent and you lose your status as an eligible dependent under the enrolled student's membership.

Whether you are the enrolled student or you are the enrolled student's spouse or other enrolled dependent, your coverage in this dental plan will end when:

- The *group* fails to pay your *premium* for your coverage in the *group's* student health plan to *Blue Cross and Blue Shield* within 30 days of the due date.
- The *group's* contract with *Blue Cross and Blue Shield* is terminated (or is not renewed).
- You commit misrepresentation or fraud to *Blue Cross and Blue Shield*. For example, you misused the ID card by letting another person not enrolled in the *group's* student health plan attempt to get coverage. Termination will go back to your *effective date*. Or, it will go back to the date of the misrepresentation or fraud, as determined by *Blue Cross and Blue Shield*, subject to applicable federal law. Or, in some cases *Blue Cross and Blue Shield* may limit your benefits.
- You commit acts of physical or verbal abuse that pose a threat to, or a threat to the health of, health care providers or other *members* or employees of *Blue Cross and Blue Shield* or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc., and these acts are not related to your physical condition or *mental condition*. In this case, this termination will follow the procedures that have been approved by the Massachusetts Commissioner of Insurance.

- You fail to comply in a material way with any provision of this dental plan. For example, if you fail to provide information that *Blue Cross and Blue Shield* requests related to your coverage in this dental plan, *Blue Cross and Blue Shield* may terminate your coverage.
- *Blue Cross and Blue Shield* discontinues this dental plan. *Blue Cross and Blue Shield* may discontinue this dental plan for any reason as of a date approved by the Massachusetts Commissioner of Insurance.

Medicare Program

Generally, the benefits that are available under the *group's* student health plan are secondary to or in excess of the benefits provided by Medicare. This means that when you are eligible for Medicare and Medicare is allowed by federal law to be the primary payor, the coverage provided by the *group's* student health plan will be reduced by the amount of benefits allowed under Medicare for the same *covered services*. This reduction will be made whether or not you actually receive the benefits from Medicare.

All other provisions remain as described in your Subscriber Certificate.