Date: 12/21/2020

To: MASS COMMUNITY COLLEGES DENTAL BLUE

Documents Provided: Subscriber Certificate(s) and Riders as of 09/01/2020

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 09/01/2020.

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.

Benefits for Services from Massachusetts Dentists Who Do Not Have Agreements with Blue Cross and Blue Shield of Massachusetts, Inc.

BCS Insurance Company (BCS) certifies that you have the right to benefits according to the terms of the contract whose terms are summarized in this Evidence of Coverage. Your Dental Blue identification card from Blue Cross and Blue Shield of Massachusetts, Inc. (Blue Cross and Blue Shield) will identify you to a dentist as a person who has the right to the benefits described in the contract, which is intended to supplement the coverage available to you under your Blue Cross and Blue Shield dental contract.

This Evidence of Coverage sets forth the terms of the contract solely between the account (your group) on your behalf and BCS Insurance Company (BCS). Your group has not entered into this contract on your behalf based upon representations by any person other than BCS, and no person, entity or organization other than BCS will be held accountable or liable to you or your group for any of BCS's obligations to you created under the contract. The contract is intended solely to supplement your coverage under the Blue Cross and Blue Shield dental contract by providing benefits for covered services you receive from Massachusetts dentists who do not have participating agreements with Blue Cross and Blue Shield. This paragraph will not create any additional obligations whatsoever on the part of BCS other than those obligations created under the contract.

Coverage from BCS

BCS will make payments to you for services you receive from Massachusetts dentists who do not have participating agreements with Blue Cross and Blue Shield.

The dental service must be necessary and appropriate to diagnose and treat your dental condition as determined by Blue Cross and Blue Shield and otherwise covered under your Blue Cross and Blue Shield dental contract.

The benefits are subject to the same deductibles, benefit maximums, and all the terms, conditions and exclusions in your Blue Cross and Blue Shield dental contract, except for the limitation on services rendered by non-participating dentists. There are no additional deductibles or benefit maximums applicable to this coverage. Like for your Blue Cross and Blue Shield dental contract, the only exclusion for preexisting conditions is that services for the treatment of congenital anomalies are not covered (except for covered orthodontic services when you have supplemental coverage for orthodontic services via an orthodontic endorsement).

Benefit payments are at the 90th percentile of the dental prevailing charge file by zip code or dentist's charge, whichever is lower. You will be responsible for the balance of the dentist's charge, up to the full amount of that charge.

How to Obtain Payment for BCS Coverage

To receive payment for services described in this Evidence of Coverage, you must submit a completed BCS Dental claim form and attach itemized bills on the dentist's letterhead. Send this information to the address on the BCS Dental claim form. Your group has a supply of these forms or you can get them from the Blue Cross and Blue Shield customer service office. Just ask for the "BCS Dental claim form."

Payment will be made directly to you. It will not be made to the dentist and you may not assign your right to benefits to the attending dentist or anyone else.

Eligibility, Enrollment, and Disenrollment

Eligibility for this coverage, including the eligibility of coverage for dependents, is subject to the same rules that apply to your Blue Cross and Blue Shield dental contract. Similarly, the criteria by which you may be disenrolled or denied enrollment are subject to the same rules that apply to your Blue Cross and Blue Shield dental contract.

Grievance Program

You have the right to a review when you disagree with a decision to deny payment for services described in this Evidence of Coverage or if you have a complaint about the care or service you received from BCS. Most problems or concerns can be handled with one phone call. For help resolving a dental problem or concern, you should first call the Blue Cross and Blue Shield customer service office at the toll-free number shown on your Blue Cross and Blue Shield Dental Blue identification card. Blue Cross and Blue Shield handle the grievance program for this coverage for BCS.

All other aspects of the grievance program are the same as those for Blue Cross and Blue Shield as described in your Blue Cross and Blue Shield dental contract.

Utilization Review

Blue Cross and Blue Shield handles utilization review for BCS under the same program described in your Blue Cross and Blue Shield dental contract.

Coordination of Benefits

The benefits described in this Evidence of Coverage are coordinated according to the same rules described in your Blue Cross and Blue Shield dental contract concerning coordination of benefits (COB), subrogation, and workers' compensation.

Prepaid Fee

The premium paid by you, or on your behalf, for this coverage is equal to 2% of the premium paid by you, or on your behalf, for dental coverage from Blue Cross and Blue Shield, which amount is reported to you in a separate document from Blue Cross and Blue Shield. Payment terms and obligations are the same as those that apply under your Blue Cross and Blue Shield dental contract.

Terms of Blue Cross and Blue Shield Dental Contract

Except as provided herein, the terms of your Blue Cross and Blue Shield dental contract are incorporated by reference and apply equally to BCS as they do to Blue Cross and Blue Shield. In particular, but without limitation, provisions in the Blue Cross and Blue Shield dental contract that apply equally to the coverage described herein include:

- pretreatment estimates;
- time limit for legal action;
- access to and confidentiality of your dental and other records;
- acts of dentists;
- changes to the contract;
- continuation of dental coverage options; and
- definitions.

Questions

If you have any questions about this coverage from BCS or about any of the matters mentioned in this contract, please contact the Blue Cross and Blue Shield customer service office by calling the number on your Dental Blue identification card.

SECRETARY

PRESIDENT

Dental Blue®

Dental Blue Program 1

Subscriber Certificate

MASSACHUSETTS

Welcome to Dental Blue

We are very pleased that you've selected a Blue Cross and Blue Shield of Massachusetts, Inc. dental plan. This document is a comprehensive description of your dental benefits, so it includes some technical language. It also explains your responsibilities — and our responsibilities — in order for you to receive the full extent of your coverage. If you need any help understanding the terms and conditions of this contract, please contact us. We're here to help!

Blue Cross and Blue Shield of Massachusetts, Inc.

Andrew Dreyfus
President

Stephanie Lovell
Clerk/Secretary

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

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**).

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Introduction

Blue Cross and Blue Shield certifies that you have the right to benefits according to the terms of this Dental Blue *contract*. This *contract* is a prepaid ("insured") group dental plan contract between the *subscriber's group* and Blue Cross and Blue Shield of Massachusetts, Inc. (*Blue Cross and Blue Shield*) to provide dental benefits to participants of the group dental plan sponsored by the *subscriber's group*. *Blue Cross and Blue Shield* will provide the benefits that are described in this *contract* as long as you are enrolled under this *contract* when you receive *covered services* (except as specifically stated otherwise in this *contract*) and the *premium* that your *group* owes for these benefits has been paid to *Blue Cross and Blue Shield*.

This Subscriber Certificate is part of the *contract* between the *subscriber's group* and Blue Cross and Blue Shield of Massachusetts, Inc., located at 101 Huntington Avenue, Suite 1300, Boston, Massachusetts 02199-7611, to provide dental benefits to you (the *member*). It explains your benefits and the terms of your membership under this *contract*. You should read this *contract* to familiarize yourself with the main provisions and keep it handy for reference. The words in italics have special meanings and are described in Part 1.

Your *group* or *Blue Cross and Blue Shield* may change the terms of this *contract* (see Part 8). If this is the case, the change is described in a *rider*. Your *plan sponsor* or *Blue Cross and Blue Shield* can supply you with any *riders* that apply to your benefits under this *contract*. Please keep any *riders* with your *contract* for easy reference.

Before using your benefits, you should remember there are limitations or exclusions. Be sure to read the limitations and exclusions on your benefits that are described in Parts 2, 3, 4 and 5.

In this *contract*, the term "you" refers to any *member* who has the right to the benefits provided under this *contract*—the *subscriber* or the enrolled spouse or any other enrolled dependent.

Member Services

Identification Cards

When you enroll for benefits under this *contract*, the *subscriber* (and the enrolled spouse, if any) will receive a Dental Blue identification (ID) card. This card is for identification purposes only. While you are a *member*, you must show your ID card to the dentist before you receive *covered services*. If your ID card is lost or stolen, you should contact the *Blue Cross and Blue Shield* customer service office. They will send you a new Dental Blue ID card. Or, you may also use the online member self service option that is located at **www.bluecrossma.com**.

Finding a Participating Dentist

To find a *participating dentist*, you may refer to the most current *Blue Cross and Blue Shield* dental provider directory for the location where you choose to obtain *covered services*.

For Services in Massachusetts or Rhode Island

To find a dentist who is a *participating dentist*, you may refer to the most current Dental Blue Directory of Providers. This provider directory lists *participating dentists* located in Massachusetts and Rhode Island. Or, for help to find a *participating dentist*, you may call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your Dental Blue ID card. Or, you may call the Physician Selection Service at **1-800-821-1388**. You may also access the online provider directory (Find a Doctor) on the *Blue Cross and Blue Shield* internet website at **www.bluecrossma.com**. Once you have found a *participating dentist,* you should check again at the time you obtain a *covered service* to make sure your dentist is still a *participating dentist*.

For Services in Other Locations (outside of Massachusetts and Rhode Island)

To find a dentist who is a *participating dentist* in the *Blue Cross and Blue Shield* designated out-of-area dental network, you may refer to the most current out-of-area dental provider directory. Or, you may call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your Dental Blue ID card (or the Physician Selection Service at 1-800-821-1388). You may also access the online out-of-area dental provider directory on the *Blue Cross and Blue Shield* internet website at **www.bluecrossma.com**. Once you have found an out-of-area *participating dentist*, you should check again at the time you obtain a *covered service* to make sure that your dentist is still in the designated out-of-area dental network.

If you do not find a dentist listed in your out-of-area dental provider directory for your specific location, you should look in the Dental Blue Directory of Providers. Whether or not you find a convenient dentist in either directory, you may continue to obtain *covered services* from an out-of-area dentist that is not in either the designated out-of-area dental network or the Dental Blue provider network. However, in this case, you must pay the difference between the claim payment and the dentist's actual charge for *covered services*.

How to Get Help for Questions

For help to understand the terms of this *contract* or to resolve a problem or concern, you may call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your Dental Blue ID card. (For TTY, call 711.) A customer service representative will work with you to help you understand

your benefits or resolve your problem or concern as quickly as possible. (See Part 7 for more information about *Blue Cross and Blue Shield's* inquiry process and the formal grievance review process.)

You can call the *Blue Cross and Blue Shield* customer service office Monday through Friday from 8:00 a.m. to 8:00 p.m. (Eastern Time). Or, you can write to: Blue Cross Blue Shield of Massachusetts, Member Service, P.O. Box 9134, North Quincy, MA 02171-9134.

Blue Cross and Blue Shield will keep a record of each inquiry you (or someone on your behalf) makes. These records, including the responses to each inquiry, will be kept for two years. They may be reviewed by the Commissioner of Insurance and Massachusetts Department of Public Health.

If you would like information and resources about various issues related to your and your family's oral health care, you may access the American Dental Association's internet website at **www.ada.org**.

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 Dental Blue 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 1

Definitions

The following terms are shown in italics in this *contract*. These terms will give you a better understanding of your benefits.

Allowed Charge

The charge that is used to calculate payment of your benefits. The *allowed charge* depends on the type of health care provider that furnishes a *covered service* to you.

- **Participating Dentists.** For *covered services* furnished by dentists who have a payment agreement to furnish dental services to *members* enrolled under Dental Blue, *Blue Cross and Blue Shield* calculates your benefits based on the provisions of the dentist's payment agreement and the dentist's contracted rate that is in effect at the time a *covered service* is furnished. This contracted rate is referred to as the dentist's *allowed charge*. **In most cases, you do not have to pay the amount of the dentist's actual charge that is in excess of the dentist's *allowed charge*.** However, there are certain situations when you will have to pay the difference between the claim payment and the dentist's actual charge. This is the case when:
  - You and your dentist decide to use a procedure that is more expensive than a less costly, but acceptable alternative. *Blue Cross and Blue Shield* will provide benefits toward the cost of the procedure with the lower fee. You pay any balance.
  - You could have received benefits or services from someone else without charge, or you have received or will receive payment from another person or insurance company. But, once these payments from the other person or insurance company have been applied to your provider balances and used up, you do not have to pay the amount in excess of the *allowed charge*.
  - You receive services from more than one dentist for the same procedure or for procedures that are furnished in a series during a planned course of treatment. In such a case, the total amount of your benefits will not be more than the amount that would have been provided had only one dentist furnished all services.

- **Non-Participating Dentists.** For *covered services* furnished by non-*participating dentists*, *Blue Cross and Blue Shield* calculates your benefits based on the Maximum Allowable Charge schedule. This is generally the same amount that is allowed for *covered services* furnished by a Massachusetts *participating dentist*. This amount may sometimes be less than the dentist's actual charge. **If this is the case, you must pay the amount of the dentist's actual charge that is in excess of the dentist's *allowed charge*.** This is in addition to the amount you would normally pay for *covered services* (for example, any *deductible* and/or coinsurance that you owe for that *covered service*). However, if the dentist's actual charge is less than the *allowed charge*, your benefits will be calculated based on the dentist's actual charge.

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 *contract*. *Blue Cross and Blue Shield* has full discretionary authority to interpret this *contract*. 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 *contract*. All determinations by *Blue Cross and Blue Shield* with respect to benefits under this *contract* will be conclusive and binding unless it can be shown that the interpretation or determination was arbitrary and capricious.

Contract

This *contract*, including this Subscriber Certificate, your Benefits Payable Riders, any other *riders* or changes to this *contract*, the *subscriber's* enrollment form and the agreement that *Blue Cross and Blue Shield* has with the *subscriber's group* to provide benefits to the *subscriber* and his or her covered dependents. This *contract* will be governed by and construed according to the laws of the Commonwealth of Massachusetts, except as preempted by federal law.

You hereby expressly acknowledge your understanding that this *contract* constitutes a contract solely between the account (your *group*) on your behalf and Blue Cross and Blue Shield of Massachusetts, Inc. (*Blue Cross and Blue Shield*), which is an independent corporation 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* has not entered into this *contract* on your behalf 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* 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*.

Covered Services

The dental services, supplies, procedures and appliances for which *Blue Cross and Blue Shield* provides benefits as described in this *contract* and any *riders* to this *contract*. (See Part 3.) These dental services, supplies, procedures and appliances must be furnished by *participating dentists* in order for you to receive the benefits provided under this *contract*. (There are a few exceptions to this requirement. See Part 8.)

Deductible

The amount that you must pay before benefits are provided for certain *covered services*. If a *deductible* applies to your benefits, the Benefits Payable Riders that are attached as part of your *contract* show the amount of your *deductible* and which *covered services* are subject to the *deductible*. In this case, the amount that is put toward your *deductible* is calculated based on the *allowed charge* or the dentist's actual charge, whichever is less (unless otherwise required by law).

Effective Date

The date, as shown on *Blue Cross and Blue Shield's* records, on which your membership under this *contract* starts. Or, the date on which a change to this *contract* takes effect.

Fracture

The breakage of sound natural teeth. This does not include crazing (small surface breaks) resulting from temperature changes or chipping due to attrition.

Group

Any corporation, partnership, individual proprietorship or other organization that has an agreement with *Blue Cross and Blue Shield* to provide dental benefits for a group of *members*. The *group* will make payment to *Blue Cross and Blue Shield* for covered *members* and will also deliver to the *members* all notices from *Blue Cross and Blue Shield*. The *group* is the *subscriber's* agent and is not the agent of *Blue Cross and Blue Shield*.

Member

You, the person who has the right to the benefits described in this *contract*. A *member* may be the *subscriber* or his or her enrolled spouse (or former spouse, if applicable) or any other enrolled dependent.

Necessary and Appropriate

All dental care, services, procedures, supplies and appliances must be *necessary and appropriate* to diagnose or treat your dental condition. *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:

- Your dental care 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 (including periodontal, endodontic and related diseases).
- Your dental care must be furnished in accordance with standards of good dental practice.
- Your dental care must not be solely for your convenience or the convenience of your dentist.

Based on a review of dental records describing your condition and treatment, *Blue Cross and Blue Shield's* staff, including dental consultants, use their professional judgment to determine available benefits for certain types of procedures, including but not limited to crown restorations, periodontal services, oral surgery, fixed bridgework and partial dentures. A dental consultant reviews the treatment plan objectively and determines whether the services are within the scope of benefits, 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.

Participating Dentist

A dentist who has a written payment agreement to furnish *covered services* to *members* enrolled under this Dental Blue *contract.* This includes a dentist who has a payment agreement with *Blue Cross and Blue Shield* and/or Blue Cross and Blue Shield of Rhode Island; or a dentist outside Massachusetts and Rhode Island who has an agreement to participate in the *Blue Cross and Blue Shield* designated out-of-area dental network. See page 2 for more information about finding a *participating dentist*.

Plan Sponsor

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 (ERISA), as amended. If you are not sure who your *plan sponsor* is, contact your employer.

Premium

The total monthly cost of your benefits under this *contract*. The *premium* amount is part of the agreement between *Blue Cross and Blue Shield* and the *group*. *Blue Cross and Blue Shield* may change your *premium* amount. Each time *Blue Cross and Blue Shield* changes the *premium*, *Blue Cross and Blue Shield* will

notify your *group* before the change is effective. It is up to the *group* to notify a *subscriber* of any *premium* changes. The *group* may require that you pay all or a portion of this *premium* amount. In all cases, the *group* must pay the total *premium* charges owed for your benefits under this *contract* to *Blue Cross and Blue Shield*. *Blue Cross and Blue Shield* is not responsible for providing benefits for a *group's member* if the *group* fails to make *premium* payments. In this case, *Blue Cross and Blue Shield* must provide notification to the *group's member*.

Rider

A "Benefits Payable Rider" which describes the amounts that you must pay for *covered services* (including *deductible* and coinsurance provisions) and any benefit limits, or an amendment that changes the terms described in this *contract*. *Blue Cross and Blue Shield* or your *group* may change the terms of your *contract*. For example, a *rider* may add or limit the benefits provided by *Blue Cross and Blue Shield* under this *contract*. A *rider* describes the material change that is made to your *contract*. You should keep any *riders* with your *contract*.

Subscriber

The eligible person who signs the enrollment form at the time of enrollment under this *contract*. This is the person on whose behalf *Blue Cross and Blue Shield* and the *plan sponsor* have entered into this *contract*.

Utilization Review

The approach that *Blue Cross and Blue Shield* uses to evaluate the *necessity and appropriateness* of many different dental procedures such as crown restorations and periodontal services. This review process involves the knowledge of dental contracts, policies and procedures in conjunction with the professional expertise of dental consultants which include dental hygienists, dental assistants and currently practicing dentists. These reviews consist of examination of dental history, radiographs, periodontal charting and narratives.

Part 2

Dental Benefits

Blue Cross and Blue Shield provides benefits for the *covered services* described in this *contract* only when: these services are furnished by a *participating dentist* or by a hygienist who is employed by the *participating dentist* (see Part 8 for a few exceptions); and your treatment is *necessary and appropriate* for you; and your treatment conforms with *Blue Cross and Blue Shield* dental policy guidelines in effect at the time *covered services* are furnished.

Benefits Payable Riders

The "Benefits Payable Riders" that are part of your *contract* describe the amounts that you must pay for *covered services*. They include an explanation of your *deductible* and coinsurance and any benefit limits that may apply. Your dental benefits will be provided based on the Benefits Payable Riders that are in effect at the time your *covered services* are furnished.

Calendar-Year Benefit Maximum

All benefits described in this *contract* are subject to a calendar-year maximum for each *member*. Your "Overall Benefit Maximum Benefits Payable Rider" shows the amount of your calendar-year benefit maximum. Any *deductible* **does not** count toward your calendar-year maximum. (If you change from one *Blue Cross and Blue Shield* dental plan to another, any dollar amount applied toward your calendar-year maximum under prior *Blue Cross and Blue Shield* dental plans will be carried over and applied to the calendar-year maximum under this *contract*.)

Pre-Treatment Estimates

Your dentist may submit a Pre-treatment Estimate to *Blue Cross and Blue Shield* in order to determine the extent to which dental services are covered. A "Pre-treatment Estimate" is a detailed description of the procedures that the dentist plans to perform and includes the charge for each procedure. *Blue Cross and Blue Shield* recommends that a Pre-treatment Estimate be submitted for any Group 2 Service expected to cost more than $250. *Blue Cross and Blue Shield* will let you and your dentist know about the extent of your benefits for the services reported. Pre-treatment Estimates are calculated based on current available benefits and *member* eligibility. Pre-treatment Estimates are not a guarantee of payment and are subject to change based on remaining benefits available and eligibility in effect at the time services are completed and a claim is submitted for payment. If your dentist does not file a Pre-treatment Estimate, *Blue Cross and Blue Shield* will decide the extent of your benefits based on a review of those services and standards that are considered generally accepted dental practice.

Part 3

Covered Services

You have the right to the benefits described in this section, except as limited or excluded in other sections of this *contract*.

Preventive Benefit Group (Group 1 Services)

Blue Cross and Blue Shield provides benefits for the following Group 1 Services to diagnose or prevent tooth decay and other forms of oral disease. These are the types of dental services most *members* receive during a routine dental check-up or visit.

Diagnostic Services

- One complete initial oral exam, including initial dental history and charting of the teeth and supporting structures.
- Single tooth radiographs (x-rays) as needed.
- Bitewing radiographs (x-rays of the crowns of the teeth), once each six months.
- Full mouth radiographs (x-rays), seven or more films, or panoramic radiograph (x-ray) with bitewing radiographs (x-rays), once each 60 months.
- Study models and casts used in planning treatment, once each 60 months.
- Emergency exams.
- Periodic or routine oral exams, once each six months.

Preventive Services

- Routine cleaning, scaling and polishing of the teeth, once each six months.
- Fluoride treatment for *members* under age 19, once each six months.
- Space maintainers required due to premature loss of teeth for *members* under age 19.
- Sealants applied to permanent premolar and molar surfaces for *members* under age 14. *Blue Cross and Blue Shield* provides benefits for one application each 48 months for each premolar or molar surface.

Basic Benefit Group (Group 2 Services)

Blue Cross and Blue Shield provides benefits for the following Group 2 Services to: restore or remove diseased or *fractured* natural teeth; replace damaged or defective restorations; treat oral disease; repair, rebase or reline dentures; repair crowns and bridges; and recement crowns, inlays, onlays and fixed bridgework.

Restorative Services

- Amalgam (silver) fillings (limited to one filling for each tooth surface in each 12 months). However, no benefits are provided for fillings on tooth surfaces where a sealant was applied within the last 12 months.
- Composite resin (tooth color) fillings on front teeth (limited to one filling for each tooth surface in each 12 months). *Blue Cross and Blue Shield* provides benefits for amalgam (silver) fillings toward the cost of composite resin (tooth color) fillings on back teeth (bicuspids and molars). You pay any balance.

- Pin retention for fillings.
- Stainless steel crowns on primary (baby) teeth.
- Stainless steel crowns on first permanent (adult) molars for *members* under age 16.

Oral Surgery
- Tooth extractions.
- Root removal.
- Biopsies.

Periodontics (Gum and Bone)
- Periodontal scaling and root planing, once in each quadrant each 24 months.
- Periodontal surgery (soft and hard tissue surgeries), once in each quadrant each 36 months.
- Periodontal maintenance following active periodontal therapy, once each three months.

Endodontics (Root and Pulp)
- Root canal therapy on permanent teeth, once in a lifetime for each tooth.
- Retreatment root canal therapy on permanent teeth, once in a lifetime for each tooth.
- Therapeutic pulpotomy on primary or permanent teeth for *members* under age 16.
- Other endodontic surgery intended to treat or remove the dental root.

Prosthetic Maintenance
- Repair of partial or complete dentures, crowns and bridges, once each 12 months.
- Adding teeth to an existing partial or complete denture.
- Rebase or reline dentures, once each 36 months.
- Recementing of crowns, inlays, onlays and fixed bridgework, once each 12 months.

Other Covered Services
- Occlusal adjustments, once each 24 months.
- Services to treat root sensitivity.
- General anesthesia when administered in conjunction with covered surgical services.
- Emergency dental treatment to relieve acute pain.
- Emergency dental treatment to control a dental condition that requires immediate care to prevent permanent harm to the *member*.

Orthodontic Services

Orthodontic services are **not** covered under this *contract* unless your *group* has purchased supplemental coverage to help pay for orthodontic services to prevent and correct misalignment of the teeth. If your *group* has purchased this coverage, these additional benefits are described in an Orthodontic Endorsement to this *contract*. If you have these benefits, *Blue Cross and Blue Shield* will supply you with the Orthodontic Endorsement that applies to your benefits for orthodontic services at the time you enroll for benefits under this *contract*. Also, if a change is made to your benefits for orthodontic services, your *plan sponsor* or *Blue Cross and Blue Shield* can supply you with the Orthodontic Endorsement that applies to your benefits for these services.

If your *group* has purchased this coverage, orthodontic benefits will be paid as follows:

- If you began orthodontic treatment prior to the *effective date* of the Orthodontic Endorsement, your dental plan will provide benefits for treatment you receive on or after your *effective date*. These benefits will be provided on a monthly basis until you complete your treatment for covered

orthodontic services or you reach your orthodontic lifetime benefit limit, whichever comes first. Depending on your stage of treatment at the time you become eligible for orthodontic coverage, the total of these monthly payments may be less than your orthodontic lifetime benefit limit.

- If you begin orthodontic treatment after the *effective date* of the Orthodontic Endorsement, your dental plan will provide an initial down payment that is equal to one half of your available orthodontic lifetime benefit amount. Then, benefits will be provided on a monthly basis until you complete your treatment for covered orthodontic services or you reach your orthodontic lifetime benefit limit, whichever comes first. The total of these payments will not be more than your orthodontic lifetime benefit limit.

Part 4

Limitations and Exclusions

The benefits described in this *contract* are limited or excluded as follows.

Multi-Stage Dental Procedures

Your dental benefits as described in Part 3 for procedures that require more than one visit (for example, root canals) will be provided as long as you are enrolled for benefits under this *contract* on the date the procedure is completed. This means that you do not have to be enrolled under this *contract* on the date the procedure is started in order to receive benefits for the *covered service*. However, if your membership under this *contract* is terminated prior to the completion date of the procedure, no benefits are provided for the entire procedure. (If you have an Orthodontic Endorsement that provides supplemental coverage for orthodontic services, this provision does not apply to those orthodontic services.)

Non-Covered Services

No benefits are provided for:

- Services, supplies, procedures or appliances to treat an illness or injury for which you have the right to benefits under government programs. These include the Veterans Administration for an illness or injury connected to military service. They also include 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 or treatment to be furnished in a public facility. No benefits are provided if you could have received governmental benefits by applying for them on time. This exclusion does not include Medicaid or Medicare.
- Charges that are received for or related to dental care that *Blue Cross and Blue Shield* considers to be experimental. The care must be documented by controlled studies that determine its merits (such as its safety) and include sufficient follow-up studies.
- Charges for appointments that you do not keep. Dentists may charge you for failing to keep your scheduled appointments. They may do so if you do not give reasonable notice to the office. Appointments that you do not keep are not counted against any benefit limits described in this *contract*.
- A service, supply, procedure or appliance that is not described as a *covered service* in this *contract*.
- Orthodontic services unless your *group* has purchased an Orthodontic Endorsement to provide supplemental coverage to help pay for these services.
- Services, supplies, procedures or appliances that do not conform with *Blue Cross and Blue Shield* dental policy guidelines.
- Any service or supply furnished along with, in preparation for, or as a result of a non-*covered service*.
- Services, supplies, procedures and appliances that are not considered *necessary and appropriate* by *Blue Cross and Blue Shield*.
- A method of treatment more costly than is customarily provided. If *Blue Cross and Blue Shield* determines that your treatment is more costly than another acceptable alternative treatment, *Blue Cross and Blue Shield* will provide benefits for the least expensive but acceptable alternative treatment that meets your needs. In this case, you pay any balance.
- Services, supplies, procedures and appliances that are furnished to someone other than the patient.
- Treatment and related services that are required by third parties.

- Free care or care for which you are not required to pay or for which you would not be required to pay if you were not covered under this *contract*.
- A service rendered by someone other than a licensed dentist or hygienist who is employed by the dentist.
- Nutrition counseling or instructions in dental hygiene, including proper methods of tooth brushing, the use of dental floss, plaque control programs and caries (cavity) susceptibility tests.
- Incomplete procedures.
- Laboratory or bacteriological tests.
- Consultations when the dentist who renders the consultation provides treatment.
- Restorations for reasons other than decay or *fracture* of teeth, such as erosion, abrasion or attrition.
- Sealants applied to permanent premolar or molar surfaces that have decay or fillings.
- Fillings on tooth surfaces where a sealant was applied within the last 12 months.
- Replacement of a filling within 12 months of the date of the prior restoration.
- Labial veneers.
- Stainless steel crowns on permanent (adult) teeth, other than on first permanent (adult) molars for *members* under age 16.
- Replacement of space maintainers for reasons such as theft, abuse, misuse, misplacement, loss, improper fit, allergies, breakage or ingestion.
- Implants or transplants, or any related surgical or restorative procedures.
- Any procedure to save a tooth when there is a poor statistical probability (less than a 70% chance) that the tooth will last for 60 months (for example, surgical periodontal regenerative procedures to stabilize a tooth loosened due to extensive periodontal disease).
- Services, supplies, procedures or appliances to stabilize teeth when required due to periodontal disease (periodontal splinting).
- A service to diagnose or treat temporomandibular joint (TMJ) disorders or myofascial (muscular) pain, including bruxism (grinding of the teeth).
- A service, supply or procedure when its sole purpose is to increase the height of teeth (vertical dimension) or to restore occlusion.
- Athletic mouth guards.
- Occlusal guards.
- A separate charge for occlusal analysis, pulp vitality testing or pulp capping since these services are usually performed as part of another covered procedure. (Your *participating dentist* cannot charge you a separate fee for these services.)
- Services that are cosmetic in nature or meant primarily to change or improve your appearance.
- Services for the treatment of congenital anomalies, except for covered orthodontic services when you have an Orthodontic Endorsement that provides supplemental coverage for orthodontic services.
- Drugs, pharmaceuticals, biologicals or other prescription agents or products.
- Analgesia (nitrous oxide) or sedation.
- Photographs.
- 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.
- Services and supplies furnished after your termination date under this *contract*. (Remember, if your membership under this *contract* is terminated prior to the completion date of a procedure that requires more than one visit, no benefits are provided for the entire procedure. See "Multi-Stage Dental Procedures" above.)
- A *covered service* 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 providing *covered services*, 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. For the purposes of this exclusion, 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).

Procedures Begun Before Effective Date

Your benefits under this *contract* are not limited based on dental conditions that are present on or before your *effective date*. But, these benefits are subject to all the provisions described in this *contract*. This means that your dental services will be covered from the *effective date* of your membership under this *contract* without a pre-existing condition restriction. No benefits will be provided under this *contract* for services that you received prior to your *effective date*. There is one exception. If before your *effective date* you started receiving services for a procedure that requires two or more visits (see "Multi-Stage Dental Procedures" above), benefits will be provided as described in Part 3 for the entire procedure as long as you are enrolled for benefits under this *contract* on the completion date of the procedure.

Part 5

Other Party Liability

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 under this *contract*, you must notify *Blue Cross and Blue Shield* if you add or change health plan coverage. Upon 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 *contract* is secondary, no 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, coverage under this *contract* will be secondary when another plan provides you with coverage for health care services.

Blue Cross and Blue Shield will not provide any more benefits than those already described in this *contract*. *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 Notice: If you fail to comply with the provisions of this COB section, payment of your claim may be denied.

Medicare Program

When you are eligible for the Medicare program and Medicare is allowed by federal law to be the primary payor, the benefits provided by *Blue Cross and Blue Shield* 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.

Blue Cross and Blue Shield Rights to Recover Benefit Payment

Subrogation and Reimbursement of Benefit Payments

If you are injured by any act or omission of another person, the benefits under this *contract* 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 health care expenses. The amount you must reimburse *Blue Cross and Blue Shield* will not be reduced by any attorney's fees or expenses you incur.

Member Cooperation

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.

Workers' Compensation

No benefits are provided for health care services that are furnished to treat an illness or injury that *Blue Cross and Blue Shield* determines was work related. This is the case even if you have an agreement with the workers' compensation carrier that releases them from paying for the claims. All employers provide their employees with workers' compensation or similar insurance. This is done to protect employees in case of a work-related illness or injury. All health care claims for a work-related illness or injury must be billed to the employer's workers' compensation carrier. It is up to you to use the workers' compensation insurance. If *Blue Cross and Blue Shield* pays for any work-related health care services, *Blue Cross and Blue Shield* has the right to get paid back from the party that legally must pay for the health care claims. *Blue Cross and Blue Shield* also has the right, where possible, to reverse payments made to providers.

If you have recovered any benefits from a workers' compensation insurer (or from an employer liability plan), *Blue Cross and Blue Shield* has the right to recover from you the amount of benefits it has paid for your health care services. This is the case even if:

- the workers' compensation benefits are in dispute or are made by means of a settlement or compromise;
- no final determination is made that an injury or illness was sustained in the course of or resulted from your employment;
- the amount of workers' compensation due to medical or health care is not agreed upon or defined by you or the workers' compensation carrier; or
- the medical or health care benefits are specifically excluded from the workers' compensation settlement or compromise.

If *Blue Cross and Blue Shield* is billed in error for these services, you must promptly call or write *Blue Cross and Blue Shield's* customer service office.

Part 6

Filing a Claim

When the Dentist Files a Claim

Your dentist will file a claim for you when you receive a *covered service* from a *participating dentist*. Just tell the dentist that you are a *member* and show him or her your Dental Blue 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 dentist directly for *covered services*.

When the Member Files a Claim

You may have to file your claim when you receive a *covered service* from a non-*participating dentist*. The 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 your dentist. To file a claim for repayment, 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. 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 services and/or supplies 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, a decision will be made and, where appropriate, payment will be made to the dentist (or to you if you sent in the claim) for your claim to the extent of your benefits described in this *contract*. Or, you and/or the dentist will be sent 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 more information is needed to make a final determination for the claim, *Blue Cross and Blue Shield* will ask for the information or records it needs within 30 calendar days of receiving the request for benefits or payment. This additional information must be provided to *Blue Cross and Blue Shield* within 45 calendar days of this request. If the additional information is provided to *Blue Cross and Blue Shield* within 45 calendar days of the request, a decision will be made within the time remaining in the original 30-day claim determination period or within 15 calendar days of the date the additional information is received, whichever is later. If the additional information is not provided to *Blue Cross and Blue Shield* within 45 calendar days of the request, the claim for benefits or payment will be denied. If the additional information is submitted after this 45 days, then it may be viewed as a new claim for benefits or payment. In this case, a decision will be made within 30 days as described previously in this section.

Part 7

Grievance Program

You have the right to a review when you disagree with a decision by *Blue Cross and Blue Shield* to deny payment for services, or if you have a complaint about the care or service you received from *Blue Cross and Blue Shield* or a *participating dentist*.

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

Making an Inquiry and/or Resolving Claim Problems or Concerns

Most problems or concerns can be handled with just one phone call. (See page 2 for more information about Member Services.) For help resolving a problem or concern, you should first call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your Dental Blue ID card. A customer service representative will work with you to help you understand your benefits or resolve your problem or concern as quickly as possible. (The formal grievance review process described below will be followed when your request for a review is because *Blue Cross and Blue Shield* has determined that a service or supply is not *necessary and appropriate* for your condition.)

When resolving a problem or concern, *Blue Cross and Blue Shield* will consider all aspects of the particular case, including the terms of your *contract*, the policies and procedures that support the *contract*, the provider's input, as well as your understanding and expectation of benefits. *Blue Cross and Blue Shield* will use every opportunity to be reasonable in finding a solution that makes sense for all parties and may use an individual case management approach when it is judged to be appropriate. *Blue Cross and Blue Shield* will follow its standard business practices guidelines when resolving your problem or concern.

If you disagree with the decision given to you by the customer service representative or *Blue Cross and Blue Shield* has not responded within three working days of receiving your inquiry, you may request a review through *Blue Cross and Blue Shield's* formal grievance program. If this is the case, *Blue Cross and Blue Shield* will notify you of the steps you may follow to request a formal grievance review.

The formal grievance review process described below will be followed when your request for a review is because *Blue Cross and Blue Shield* has determined that a service or supply is not *necessary and appropriate* for your condition.

Formal Grievance Review

How to Request a Grievance Review

To request a formal review from *Blue Cross and Blue Shield's* Member Grievance Program, you (or your authorized or legal representative) have three options.

- 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 request 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.

- Or, you may send your grievance to *Blue Cross and Blue Shield's* Member Grievance Program internet address 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.

- Or, you may call *Blue Cross and Blue Shield's* Member Grievance Program at **1-800-472-2689**. When your request is made by telephone, *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, ask for more information as needed and let you know in writing of the decision or the outcome of the review. If your grievance is regarding termination of 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 coverage does not apply to services that are limited by dollar or visit maximums and that exceed those maximums, 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 name and identification number of the *member* asking for the review; 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/dental records and treatment information that relate to your 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/dental 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.

Choosing an Authorized Representative
You may choose to have another person act on your behalf during the grievance review process. Except as described below, you must designate this person in writing to *Blue Cross and Blue Shield*.

If your claim is for emergency services, a health care professional who has knowledge about your dental condition may act as your authorized representative. In this case, you do not have to designate the health care professional in writing. If you are not able to designate another person to act on your behalf, then a conservator, a person with power of attorney, or a family member may act as your authorized representative. Or, he or she may appoint someone else to act as your authorized representative.

Who Handles the Grievance Review
All grievances are reviewed by individuals who are knowledgeable about *Blue Cross and Blue Shield* and the issues involved in the grievance. The individuals who will review your grievance will be those who did not participate 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 professional in the same or similar specialty that usually treats the medical/dental condition, performs the procedure 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. Every reasonable effort will be made to speed up the review of grievances that involve health care services that are soon to be obtained by the *member*. (When the grievance review is for services you have already obtained and it requires a review of your medical/dental 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 calendar days after you are asked for it, *Blue Cross and Blue Shield* may make a final decision about your grievance without that medical/dental information.)

Important Note: If your grievance review began 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.

Blue Cross and Blue Shield may extend the time frame to complete a grievance review, with your permission, in cases when *Blue Cross and Blue Shield* and the *member* agree that additional time is required to fully investigate and respond to the grievance. A grievance that is not acted upon within the specified time frames 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 coverage for all or part of a health care service or supply, *Blue Cross and Blue Shield's* response will explain the reasons. It will give you the specific medical and scientific reasons for the denial and a description of alternative treatment, health care services and supplies that would be covered.

Grievance Records
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
In place of the formal grievance review described above, you have the right to request an "expedited" review right away when your situation is for immediate or urgently-needed services. *Blue Cross and Blue Shield* will review and respond to grievances for immediate or urgently-needed services as follows:

- When your grievance review concerns medical care or treatment for which waiting for a response under the grievance review timeframes described above 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, or if your physician says that you will have severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance review, *Blue Cross and Blue Shield* will review your grievance and notify you of the decision within 72 hours after your request is received.
- When a grievance review is requested while the *member* is an inpatient, *Blue Cross and Blue Shield* will complete the review and make a decision regarding the request before the patient is discharged from that inpatient stay. Coverage for those services in dispute will continue until this review is completed.

- A decision to deny payment for health care services may be reversed within 48 hours if the *member's* attending physician certifies that a denial for those health care services would create a substantial risk of serious harm to the *member* if the *member* were to wait for the outcome of the normal grievance process.
- A grievance review requested by a *member* with a terminal illness will be completed within five working days of receiving the request. In this case, if the expedited review results in a denial for health care services or treatment, *Blue Cross and Blue Shield* will send a letter to the *member* within five working days that explains the specific medical and scientific reasons for the denial and a description of alternative treatment, health care services and supplies that would be covered and information about requesting a hearing. When the *member* requests a hearing, the hearing will be held within ten days (or within five working days if the attending physician determines after consultation with *Blue Cross and Blue Shield's* Medical Director and based on standard medical practice that the effectiveness of the health care service, supply or treatment would be materially reduced if it were not furnished at the earliest possible date). You and/or your authorized or legal representative(s) may attend this hearing.

Part 8

Other Contract Provisions

Access to and Confidentiality of Dental or Medical Records

Blue Cross and Blue Shield and health care providers may, in accordance with applicable law, have access to all dental or medical records and related information needed by *Blue Cross and Blue Shield* or health care providers. *Blue Cross and Blue Shield* may collect information from health care providers, other insurance companies or the *plan sponsor* to help *Blue Cross and Blue Shield* administer the benefits described in this *contract* and to get facts on the quality of care provided under this and other health care contracts. In accordance with law, *Blue Cross and Blue Shield* and health care providers may use this information, and may disclose it to necessary persons and entities as follows:

- For administering benefits (including coordination of benefits with other insurance plans); 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*.
- For bona fide medical research according to the regulations of the U.S. Department of Health and Human Services and the Food and Drug Administration for the protection of human subjects.
- As required by law or valid court order.
- As required by government or regulatory agencies.
- As required by the *subscriber's group* or its auditors to ensure that *Blue Cross and Blue Shield* is administering your benefits properly.

Blue Cross and Blue Shield will not share information about you with the Medical Information Bureau (MIB). Except as described above, *Blue Cross and Blue Shield* will keep all information confidential and not disclose it without your consent. 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 information that you believe is not correct. *Blue Cross and Blue Shield* may charge a reasonable fee for copying records, unless your request is because *Blue Cross and Blue Shield* is declining or terminating your benefits under this *contract.*

Important Notice: To obtain a copy of *Blue Cross and Blue Shield's* Commitment to Confidentiality statement ("Notice of Privacy Practices"), call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your Dental Blue ID card.

Acts of Dentists

Blue Cross and Blue Shield is not liable for the acts or omissions by any dentists that furnish care or services to you. In addition, a *participating dentist* 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 *participating dentists*. *Blue Cross and Blue Shield* will not interfere with the relationship between dentists and their patients. You are free to select or discharge any dentist. It is not up to *Blue Cross and Blue Shield* to find a dentist for you. *Blue Cross and Blue Shield* is not responsible if a dentist refuses to furnish services to you.

Assignment of Benefits

You cannot assign any benefit or monies due under this *contract* 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 provided under this *contract* to another person or organization. There is one exception to this rule. If Medicaid has already paid the provider, you can assign your benefits to Medicaid.

Authorized Representative and Legal Representative

You may choose to have another person act on your behalf concerning your benefits under this *contract*. Some examples are a designated authorized representative or a documented legal representative. An authorized representative is a person you have chosen to help with your health care issues and to whom *Blue Cross and Blue Shield* is allowed to disclose and discuss your protected health information (PHI). An authorized representative is not a person who has legal authority to act on your behalf. A legal representative is a person who has legal authority to act on your behalf in making decisions about your health care. He or she may be someone who has legal authority for: power of attorney for health care; guardianship; conservatorship; executor of estate; or health care proxy. A legal representative may also be a person documented through a court order to act on your behalf in making decisions about your health care. To designate an authorized representative or document a legal representative, you must let *Blue Cross and Blue Shield* know in writing by completing the appropriate form(s). To get copies of these forms, you can call the *Blue Cross and Blue Shield* customer service office. The toll-free telephone number to call is shown on your Dental Blue ID card. In some cases, *Blue Cross and Blue Shield* may consider your dentist 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 may ask your dentist for more information if more is needed to make a determination about your dental benefits. *Blue Cross and Blue Shield* will consider the dentist to be your authorized representative for emergency services. *Blue Cross and Blue Shield* will continue to send benefit payments and written communications regarding your health care coverage according to *Blue Cross and Blue Shield's* standard practices, unless you specifically ask *Blue Cross and Blue Shield* to do otherwise.

Changes to This Contract

The *plan sponsor* or *Blue Cross and Blue Shield* may change a part of this *contract*. For example, a change may be made to the amount you must pay for certain services. When *Blue Cross and Blue Shield* makes a change to this *contract*, the *plan sponsor* will be notified at least 60 days before the *effective date* of the change. The notice will describe the change being made. It will also give the *effective date* of the change.

Process to Develop Clinical Guidelines and Utilization Review Criteria

Blue Cross and Blue Shield applies the following *necessary and appropriate* guidelines to develop its clinical guidelines and *utilization review* criteria. In developing these, *Blue Cross and Blue Shield* carefully assesses a treatment to determine that it is:

- 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 (including periodontal, endodontic and related diseases);
- Consistent with standards of good dental practice; and
- As cost effective as any established alternatives.

Blue Cross and Blue Shield reviews clinical guidelines and *utilization review* criteria periodically to reflect new treatments, applications and technologies.

Quality Assurance Program

Blue Cross and Blue Shield has implemented standardized Quality Assurance and Training programs and performance measurements that are designed to ensure accuracy in claims processing and to provide world class customer service to its *members*. In addition, management and technology solutions have been implemented to help customer service representatives resolve issues quickly and accurately. For example, while the *member* is still on the telephone with a *Blue Cross and Blue Shield* customer service representative, a call can be made directly to a dentist to try to resolve claim problems.

Services Furnished by Non-Participating Dentists

Covered Services Furnished In Massachusetts

The benefits described in this *contract* are provided only when *covered services* are furnished by a *participating dentist*. There are a few exceptions to this requirement. *Blue Cross and Blue Shield* will provide benefits for *covered services* furnished in Massachusetts by non-*participating dentists* but only in the following situations:

- You receive *covered services* that are furnished in an emergency and a *participating dentist* is not reasonably available.
- The *participating dentist* of a *member* with a terminal illness is involuntarily disenrolled (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. (These benefits are provided when the terminally ill *member* is expected to live six months or less as determined by a physician.)

Covered Services Furnished Outside Massachusetts

The benefits described in this *contract* are also provided when you receive *covered services* outside Massachusetts from dentists that **do not** have a written payment agreement to provide *covered services* for Dental Blue *members* as long as: the dentist is licensed in a jurisdiction having licensing requirements substantially similar to those in Massachusetts; and the dentist meets the educational and clinical standards *Blue Cross and Blue Shield* requires for *participating dentists*. You will have to pay the difference between the claim payment and the dentist's actual charge for *covered services*.

Time Limit for Legal Action

Before pursuing a legal action against *Blue Cross and Blue Shield* for any claim under this contract, you must complete *Blue Cross and Blue Shield's* formal grievance review (see Part 7). If, after completing the grievance review, you choose to bring legal action against *Blue Cross and Blue Shield*, this action must be brought within two years after the cause of action arises. For example, if you are filing a legal action because you were denied a service or a claim for benefits under this *contract*, 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 you were first sent a notice of the service or claim denial. Going through the formal grievance process does not extend the two-year limit for filing a lawsuit.

Part 9

Eligibility for Coverage

Who Is Eligible to Enroll

Eligible Employee

An employee is eligible to enroll as a *subscriber* under this *contract* 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* health care benefits. For details, contact your *plan sponsor*.

Eligible Spouse

The *subscriber* may enroll an eligible spouse for coverage under his or her membership under this *contract*. An "eligible spouse" includes the *subscriber's* legal spouse. (A legal civil union spouse, where applicable, is eligible to enroll under this *contract* 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 divorce or 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* membership, whether or not the judgment was entered prior to the *effective date* of this *contract*. This coverage is provided with no additional *premium*. The former spouse will remain eligible for this coverage **only** until the *subscriber* is no longer required by the judgment to provide health insurance for the former spouse or the *subscriber* 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 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.)

In the event the *subscriber* remarries, the former spouse may continue coverage under a separate membership with the *subscriber's group*, provided the divorce judgment requires that the *subscriber* provide health insurance for the former spouse. This is true even if the *subscriber's* new spouse is not enrolled under the *subscriber's* membership.

Eligible Dependents

The *subscriber* may enroll eligible dependents for coverage under his or her membership under this *contract*. "Eligible dependents" include the *subscriber's* or spouse's (or if applicable, legal civil union spouse'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 be a dependent on the *subscriber's* or spouse's (or if applicable, legal civil union spouse'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* 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* membership. The dependent child's spouse is **not** eligible to enroll as a dependent for coverage under the *subscriber's* 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) 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* 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* membership will continue to be covered after he or she would otherwise lose dependent eligibility under the *subscriber'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 *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* 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 described in this section may differ from the federal tax laws that define who may qualify as a dependent.

Enrollment Periods

You may enroll under this *contract* on your initial eligibility date as determined by your *group*. To enroll, you must complete the enrollment form provided in your enrollment packet and return it to the address specified in the enrollment packet no later than 30 days after your eligibility date. If you choose not to enroll under this *contract* within 30 days of your initial eligibility date, you may enroll only during an annual open enrollment period or after a qualifying event as provided by law. 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 to all eligible employees. To enroll under this *contract* during this enrollment period, you must complete the enrollment form provided in your enrollment packet and return it no later than the date specified in the enrollment packet.

See Part 11 for information about continuation of coverage when you lose eligibility for membership under this *contract*.

Making Membership Changes

Generally, you may make membership changes (for example, change from an individual membership to a family membership) only if you have a change in family status such as:

- Marriage or divorce.
- Birth, adoption or change in custody of a child.
- Death of an enrolled spouse or dependent child.
- The loss of an enrolled dependent's eligibility under the *subscriber's* 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 your *plan sponsor*. The *plan sponsor* will send you any special forms you may need.

You must request the membership change within 30 days of the reason for the change. If you do not make the change within 30 days, you will have to wait until the *group's* next open enrollment period to make the change. All membership changes or any additions are allowed only when they comply with the conditions outlined in this *contract* and in *Blue Cross and Blue Shield's* Manual of Underwriting Guidelines for Group Business.

Part 10

Termination of Coverage

Loss of Eligibility for Coverage Under This Contract

You are no longer eligible for membership under this *contract* when:

- The *subscriber* loses eligibility for health care 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 set by the *group* for eligibility under this *contract*.
- You lose eligibility as a dependent under the *subscriber's* membership. When a dependent child loses eligibility for coverage, the termination date of membership under this *contract* will be the date on which eligibility is lost.
- The *subscriber* dies.
- The *plan sponsor* fails to pay your *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 membership in accordance with the Code of Massachusetts Regulations. This notice will give you information about the termination of your membership and your options, if any, to continue *Blue Cross and Blue Shield* coverage.
- The *subscriber's group* terminates (or does not renew) this *contract*.

In any of these situations, your membership under this *contract* will be terminated as of the date you lose eligibility.

Termination by the Subscriber

Your membership under this *contract* ends when the *subscriber* chooses to cancel his or her contract 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 by Blue Cross and Blue Shield

You do not have to worry that *Blue Cross and Blue Shield* will cancel you 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 membership under this *contract* **only when**:

- You committed misrepresentation or fraud to *Blue Cross and Blue Shield*. For example, you gave false or misleading information on the enrollment application form. Or, you misused the Dental Blue ID card by letting another person not enrolled under this *contract* attempt to get benefits. This 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*.
- You commit acts of physical or verbal abuse that pose a threat to, or a threat to the health of, *participating dentists* or other *members* or employees of *Blue Cross and Blue Shield* or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. and that are not related to your physical condition or mental condition. This termination will follow procedures approved by the Massachusetts Commissioner of Insurance.
- *Blue Cross and Blue Shield* cancels this *contract* for any reason as of a date approved by the Massachusetts Commissioner of Insurance (without prior notice) or cancels all contracts of this type as of any date.

Part 11

Continuation of Coverage

Family and Medical Leave Act

An employee may continue membership under this *contract* as provided by the Family and Medical Leave Act. The Family and Medical Leave Act will generally apply to you if your *group* has 50 or more employees. For more information, contact your *plan sponsor*. If the employee chooses to continue coverage during a qualifying leave, the employee will be given the same health care benefits that would have been provided if the employee were working, with the same *premium* contribution ratio. If the employee's *premium* for continued membership under this *contract* is more than 30 days late, the *plan sponsor* will send written notice to the employee. It will tell the employee that his or her membership will be terminated. It will also give the date of the termination if payment is not received by that date. This notice will be mailed at least 15 days before the termination date.

If membership under this *contract* is discontinued for non-payment of *premium*, the employee's coverage will be restored when he or she returns to work to the same level of benefits as those the employee would have had if the leave had not been taken and the *premium* payment(s) had not been missed. This includes coverage for eligible dependents. The employee will not be required to meet any qualification requirements imposed by *Blue Cross and Blue Shield* when he or she returns to work. This includes: new or additional waiting periods; waiting for an open enrollment period; or passing a medical exam to reinstate coverage. You should contact your *plan sponsor* with any questions that you may have about your coverage during a leave of absence.

Limited Extension of Group Coverage Under State Law

When you lose eligibility for membership under this *contract* due to a plant closing or a partial plant closing in Massachusetts, you may be eligible to continue this coverage as provided by state law. If this situation applies to you, coverage may continue for up to 90 days after the plant closing. To continue this coverage, you and your *group* will each pay your share of the *premium* cost. If you become eligible for coverage under another employer sponsored health care plan at any time before this 90-day extension period ends, continued coverage under this *contract* under these provisions also ends.

If this situation applies to you, you may also be eligible for continued coverage under other state laws or under federal law. (See below for more information.) If you are, the starting date for continued coverage under these laws will be the same. But, after this 90-day extension period ends, you may have to pay additional *premium* to continue your coverage under this *contract*.

Continuation of Group Coverage Under Federal or State Law

When you are no longer eligible for membership under this *contract*, you may be eligible to continue this coverage as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA) or under Massachusetts state law. (These provisions apply to you if your *group* has two or more employees.) To continue this coverage, you will pay up to 102% of the *premium* cost to your *plan sponsor*. These laws apply to you if you lose eligibility for 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 membership. This is the case **only** until the employee is no longer required by law to provide health insurance for the former spouse or the employee or former spouse remarries, whichever comes first. The former spouse's eligibility for continued coverage will start on the date of divorce, even if he or she continues coverage under the employee's membership. While the former spouse continues coverage under the employee's membership, there is no additional *premium*. After remarriage, under state and federal law, the former spouse may be eligible to continue coverage under an individual membership for additional *premium*.)
- Death of the *subscriber*.
- Loss of status as an eligible dependent.

The period of this continued coverage begins with the date of your qualifying event. And, the length of this continued 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.)

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

Additional Continued 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 coverage will remain in effect 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 the 11 additional months, eligibility for disability is lost, coverage may terminate before the 29 months is completed. You should contact your *plan sponsor* for more information about continued 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 membership under this *contract* as a result of a bankruptcy proceeding (Title 11 of the United States Code) is also eligible to continue this coverage as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA) or under Massachusetts state law. A retired employee and/or the surviving spouse of a deceased retired employee may enroll for lifetime continued 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 coverage as of the date *group* eligibility is lost. Spouses and/or eligible dependent children of these retired employees may enroll for continued coverage until the retired employee dies. Once the retired employee dies, his or her surviving spouse and/or eligible dependent children may enroll for up to an additional 36 months of continued coverage beyond the date of the retired employee's death. (Lifetime continued coverage for retired employees will end if the *group* terminates its agreement with *Blue Cross and Blue Shield* to provide the coverage described in this *contract* or for any of the other reasons described below. See "Termination of Continued Coverage.")

Enrollment for Continued Coverage
In order to enroll for continued coverage under this *contract*, 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 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 coverage under this *contract*. (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 Coverage
Your continued coverage will end when:

- The length of time allowed for continued 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 *premiums*.
- You enroll in another employer sponsored health care plan **and** that plan does not include pre-existing condition limitations or waiting periods.

In addition, your continued coverage under this *contract* will end when the *group* terminates its agreement with *Blue Cross and Blue Shield* to provide the coverage described in this *contract*. In this case, coverage may continue under another *group* health care plan. Contact your *plan sponsor* or *Blue Cross and Blue Shield* for more information.

The longer time allowed for continued coverage for disabled *members* will end when the *member* is no longer disabled.

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attached to and made part of
Blue Cross and Blue Shield of Massachusetts, Inc.
Dental Blue Subscriber Certificate

Benefits Payable Rider

This Benefits Payable Rider modifies the terms of your dental plan and explains how your benefits are provided. Please keep this *rider* with your Subscriber Certificate for easy reference.

Under this dental plan, *Blue Cross and Blue Shield* provides benefits for *covered services* only when these services are furnished by a *participating dentist*. There are a few exceptions to this requirement. Refer to your Subscriber Certificate for information about how to find a *participating dentist* and for those situations when you may receive benefits for *covered services* furnished by a non-*participating dentist*.

Covered Services	**Your Cost Is:**
Blue Cross and Blue Shield will pay up to an overall benefit maximum in each calendar year for all your benefits under this dental plan. Until these benefits have been paid, you pay:	
Preventive Benefit Group Group 1 Services	No charge
Basic Benefit Group Group 2 Services	20% of *allowed charge* after *deductible*

Important Note: Your benefits will be calculated based on the *allowed charge*. Refer to your Subscriber Certificate for a description of "*allowed charge*" and when you may also have to pay charges that are in excess of the *allowed charge* for *covered services*.

All other provisions remain as described in your Subscriber Certificate.

attached to and made part of
Blue Cross and Blue Shield of Massachusetts, Inc.
Dental Blue Subscriber Certificate and Dental Blue PPO Subscriber Certificate

Rider
Accumulated Maximum Rollover Benefit

This *rider* modifies the terms of your dental plan. Please keep this *rider* with your Subscriber Certificate for easy reference.

Your dental plan includes an Accumulated Maximum Rollover Benefit. This rollover benefit allows you to roll over a certain dollar amount of your unused annual dental benefits so that you can use them in a future year. You can use some or all of your rollover benefits to add to your annual benefit maximum whenever your costs for covered dental services are more than your annual benefit maximum.

How This Accumulated Maximum Rollover Benefit Works

Your *group* selects the annual overall benefit maximum amount* for your dental plan along with this Accumulated Maximum Rollover Benefit. The annual rollover benefit is set based on the amount of your annual overall benefit maximum. To be eligible for the annual rollover benefit in any one year, you must meet a few conditions. First, you must have received some dental benefits under your *group's* dental plan during the year. And during that year, the total amount of the benefits you receive is less than the annual claims threshold maximum amount. If this happens, the rollover benefit will be available for you to use during the next year. But, you will not lose your rollover benefit if you do not use it during the next year. If you do not use it, your annual rollover benefit will accumulate toward the maximum rollover benefit. Your rollover benefits will be used during any year when you receive covered dental services that exceed your annual overall benefit maximum and you are still enrolled in your *group's* dental plan and the *group* continues to offer this rollover benefit.

The following amounts apply for your Accumulated Maximum Rollover Benefit.

Annual Overall Benefit Maximum Amount	Annual Claims Threshold Maximum Amount	Annual Rollover Benefit	Accumulated Maximum Rollover Benefit
See your Overall Benefit Maximum *rider**	$500	$350	$1,000
(These amounts apply when the annual overall benefit maximum is an amount from $1,000 to $1,249.)			

*Each year at the time your *group* renews this dental plan, your *group* may change your annual overall benefit maximum amount. The amount of your annual overall benefit maximum is shown in your Benefits Payable Rider that forms a part of your dental *contract*.

The following terms and their meanings will help you to understand your Accumulated Maximum Rollover Benefit.

- **Annual Claims Threshold Maximum Amount**
  This term refers to the fixed annual dollar amount that your claims must not exceed in that year for you to be eligible for that year's annual rollover benefit. In any one year, if your claims for that year are more than the fixed annual claims threshold maximum amount, you will not be eligible for the annual rollover benefit for that one year. (In this case, you may still use a prior year's rollover benefit when you receive covered dental services that exceed your annual overall benefit maximum.)

- **Annual Rollover Benefit**
  This term refers to the fixed annual dollar amount that you can roll over to a following year to pay for covered dental services as long as you meet the conditions to be eligible for the annual rollover benefit. In any one year, if your claims for that year are more than the annual threshold claims maximum amount, you will not be eligible to receive the annual rollover benefit for that one year. (In this case, you may still use a prior year's rollover benefit when you receive covered dental services that exceed your annual overall benefit maximum.)
- **Accumulated Maximum Rollover Benefit**
  This term refers to the fixed dollar amount that is the most that you can accumulate toward your rollover benefit. If your *group* changes your annual overall benefit maximum amount, the accumulated maximum rollover benefit amount may also change. The *rider* that you receive each year with your dental plan will show the accumulated maximum rollover benefit for your *group's* dental plan.

Important Restriction:	Any rollover benefits that you have cannot be used to pay for orthodontic services that are covered by this dental plan.

When Your Accumulated Maximum Rollover Benefit Ends

You will lose your right to any annual rollover benefit (or accumulated maximum rollover benefit) when you lose eligibility for coverage in your *group's* dental plan. The accumulated rollover benefit can be used only while you are enrolled in your *group's* dental plan and while your *group* continues to offer the Accumulated Maximum Rollover Benefit. This means that if you change from one group dental plan to another group's dental plan, or if your dental plan is terminated, you lose your right to any rollover benefit that has not been used.

All other provisions remain as described in your Subscriber Certificate.

attached to and made part of
Blue Cross and Blue Shield of Massachusetts, Inc.
Dental Blue Subscriber Certificate and Dental Blue PPO Subscriber Certificate

Deductible
Benefits Payable Rider

This Benefits Payable Rider modifies the terms of your dental plan. Please keep this *rider* with your Subscriber Certificate for easy reference.

The benefits described in your Subscriber Certificate for certain *covered services* are subject to a *deductible*.

Your *deductible* per calendar year is: $50 per *member*
$150 per family

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.

All other provisions remain as described in your Subscriber Certificate.

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Dental Blue Subscriber Certificate

Rider
Enhanced Dental Benefits

This *rider* modifies the terms of your dental plan. Please keep this *rider* with your Subscriber Certificate for easy reference.

Your dental plan has been changed to include Enhanced Dental Benefits for certain dental care services.

For each *member* who is eligible to receive these Enhanced Dental Benefits, *Blue Cross and Blue Shield* will provide coverage for the following dental care services:

- Dental cleanings (oral prophylaxis or periodontal maintenance cleanings) once every three months. (There must be at least three months between any cleanings covered under your dental plan, including these Enhanced Dental Benefits.)
- A periodontal scaling once for each quadrant every 24 months when this service is *necessary and appropriate*.

For these enhanced benefits, the *deductible*, coinsurance, and calendar-year benefit maximum provisions that would otherwise apply for your dental benefits do **not** apply. However, these additional dental services must still be furnished by a covered dentist.

Who Is Eligible for Enhanced Dental Benefits

You are eligible to receive these enhanced benefits when one of the following situations applies:

- You are a *member* who has been diagnosed with diabetes; or
- You are a *member* who has been diagnosed with coronary artery disease; or
- You are a *member* who has suffered a stroke; or
- You are a *member* who is pregnant.

These enhanced benefits will be available for the entire duration of the medical condition that makes you eligible for these benefits, as long as you continue to be enrolled in a Dental Blue *contract* that includes this *rider*. From time to time, *Blue Cross and Blue Shield* may ask you to submit documentation from your physician that your medical condition still qualifies you to receive coverage for these additional dental services.

To find out more about these enhanced benefits or how to qualify for these enhanced benefits, you may call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your dental plan identification card.

All other provisions remain as described in your Subscriber Certificate.

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Blue Cross and Blue Shield of Massachusetts, Inc.
Dental Blue Subscriber Certificate

Rider
Enhanced Dental Benefits

This *rider* modifies the terms of your dental plan. Please keep this *rider* with your Subscriber Certificate for easy reference.

Your dental plan has been changed to include Enhanced Dental Benefits for certain dental care services.

For *members* who have been diagnosed with oral cancer or Sjögren's syndrome, *Blue Cross and Blue Shield* will provide additional coverage for the following dental care services:

- Dental cleanings (oral prophylaxis or periodontal maintenance cleanings), once each three months. (There must be at least three months between any cleanings covered under your dental plan, including these enhanced benefits.)
- Fluoride treatment, once each three months.
- Pre-diagnostic cancer screening, once each six months.

For these enhanced benefits, the *deductible*, coinsurance, and calendar-year benefit maximum provisions that would otherwise apply for your dental benefits do **not** apply. However, these additional dental services must still be furnished by a covered dentist.

These enhanced benefits will be available for the entire duration of the medical condition that makes you eligible for these benefits, as long as you continue to be enrolled in a Dental Blue *contract* that includes this *rider*. From time to time, *Blue Cross and Blue Shield* may ask you to submit documentation from your physician that your medical condition still qualifies you to receive coverage for these additional dental services.

To find out more about these enhanced benefits or how to qualify for these enhanced benefits, you may call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your dental plan identification card.

All other provisions remain as described in your Subscriber Certificate.

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Dental Blue Subscriber Certificate and Dental Blue PPO Subscriber Certificate

Overall Benefit Maximum
Benefits Payable Rider

This Benefits Payable Rider modifies the terms of your dental plan. Please keep this *rider* with your Subscriber Certificate for easy reference.

All benefits described in your Subscriber Certificate are subject to a $1,000 calendar year overall benefit maximum for each *member*.

(If you change from one *Blue Cross and Blue Shield* dental plan to another, any dollar amount applied toward your overall benefit maximum under the prior dental plan(s) will be carried over and applied to the overall benefit maximum under this dental plan.)

Note: This overall benefit maximum does not apply to any orthodontic benefits that may be covered under this dental plan.

All other provisions remain as described in your Subscriber Certificate.

attached to and made part of
Blue Cross and Blue Shield of Massachusetts, Inc.
Dental Blue Subscriber Certificate

Rider
Non-Participating Dentists

This *rider* modifies the terms of your dental plan. Please keep this *rider* with your Subscriber Certificate for easy reference.

The amount that *Blue Cross and Blue Shield* uses to calculate payment of your dental benefits for *covered services* furnished outside Massachusetts has been changed.

For *covered services* furnished by non-*participating dentists* outside Massachusetts, *Blue Cross and Blue Shield* calculates your benefit payment based on the 90th percentile of the dental prevailing charges in the zip code region where the services are furnished, but no more than the dentist's actual charge. This amount is sometimes less than the dentist's actual charge. In this case, you must pay the amount of the actual charge that is in excess of the *allowed charge*. This is in addition to the amount you would normally pay for *covered services*.

All other provisions remain as described in your Subscriber Certificate.

attached to and made part of
Blue Cross and Blue Shield of Massachusetts, Inc.
Dental Blue Subscriber Certificate

Rider
Restorative Services

This *rider* modifies the terms of your dental plan. Please keep this *rider* with your Subscriber Certificate for easy reference.

The benefits described in your Subscriber Certificate for composite resin (tooth color fillings) have been changed.

The benefits described in your Subscriber Certificate for composite resin (tooth color) fillings on front teeth are also provided for composite resin (tooth color) fillings on back teeth (bicuspids and molars).

In addition, *Blue Cross and Blue Shield* no longer provides benefits only for an amalgam (silver) filling toward the cost of a composite resin (tooth color) filling. Instead, *Blue Cross and Blue Shield* uses the *allowed charge* for the composite resin (tooth color) filling to calculate this benefit payment. Except for those instances described in your Subscriber Certificate, you do not have to pay the amount of the dentist's actual charge that is in excess of the *allowed charge* for a composite resin (tooth color) filling.

Note: Your Benefits Payable Rider explains the amount of your benefits for these *covered services*.

All other provisions remain as described in your Subscriber Certificate.