

## Schedule of Dental Benefits

### Pediatric Essential Benefits

This is the *Schedule of Dental Benefits* that is a part of your Dental Blue Pediatric Essential Benefits Plan. This schedule describes the dental services that are covered by your dental plan for *members* who are eligible for pediatric essential dental benefits. It also shows the cost-sharing amounts you must pay for these *covered services*. Do not rely on this schedule alone. **You should read all parts of your dental plan benefit booklet to become familiar with the key points. Be sure to read the descriptions of covered services and the limitations and exclusions.** You should keep your dental plan handy so that you can refer to it. The words that are shown in italics have special meanings. These words are explained in Part 7 of your benefit booklet.

#### Who Is Eligible for Pediatric Essential Dental Benefits

The dental benefits described in this dental plan are provided for a *member* only until the end of the calendar month in which the *member* turns age 19 (or as required by federal law).

#### Annual Deductible

Your <i>deductible</i> each <i>plan year</i> :	\$50 per eligible <i>member</i> (no more than \$150 for three or more <i>members</i> who are eligible for pediatric essential dental benefits and who are enrolled under the same family membership)
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The *deductible* is the cost you have to pay during the annual coverage period (as shown above) before benefits will be paid. The *deductible* applies to Group 2 and Group 3 services only. A *deductible* does not apply to Group 1 services or to Orthodontic Services. See the chart that starts on the next page for how much you pay for *covered services* you receive after you meet the *deductible* (when it applies).

#### Annual Out-of-Pocket Maximum

Your <i>out-of-pocket maximum</i> each <i>plan year</i> :	\$350 per <i>member</i> (no more than \$700 for two or more <i>members</i> who are eligible for pediatric essential dental benefits and who are enrolled under the same family membership)
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Your *out-of-pocket maximum* is the most you could pay during the annual coverage period (as shown above) for your share of the costs for *covered services*—your cost-sharing amounts. This *out-of-pocket maximum* helps you plan for health care expenses. Even though you pay the following costs, they do not count toward your *out-of-pocket maximum*: costs for your dental plan; any *balance-billed* charges; all dental services for *members* who are not eligible for pediatric essential dental benefits; and all services this dental plan does not cover.

#### Annual Overall Benefit Limit for What the Plan Pays

Your overall benefit limit:	None
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## Schedule of Dental Benefits (continued)

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

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

You should be sure to read all parts of your dental plan to understand the requirements that you must follow to receive all of your dental benefits. You will receive these dental benefits as long as:

- You are a *member* who is eligible to receive pediatric essential dental benefits.
- Your dental service is a *covered service* as described in this dental plan benefit booklet and *Schedule of Dental Benefits*.
- Your dental service is *necessary and appropriate* as determined by *Blue Cross and Blue Shield*.
- Your dental service conforms to *Blue Cross and Blue Shield* dental guidelines and *utilization review*.
- You use a *participating dentist* to get a *covered service*, except as noted in this dental plan.

Covered Services		Your Cost Is:
<b>Group 1— Preventive Services and Diagnostic Services</b>		No charge
Oral exams	<ul style="list-style-type: none"> <li>• One complete initial oral exam per provider or location (includes initial history and charting of teeth and supporting structures)</li> <li>• Periodic or routine oral exams; twice in a calendar year</li> <li>• Oral exams for a <i>member</i> under age three; twice in a calendar year</li> <li>• Limited oral exams; twice in a calendar year</li> </ul>	
X-rays	<ul style="list-style-type: none"> <li>• Single tooth x-rays; no more than one per visit</li> <li>• Bitewing x-rays; twice in a calendar year</li> <li>• Full mouth x-rays; once in three calendar years per provider or location</li> <li>• Panoramic x-rays; once in three calendar years per provider or location</li> </ul>	
Routine dental care	<ul style="list-style-type: none"> <li>• Routine cleaning, minor scaling, and polishing of the teeth; twice in a calendar year</li> <li>• Fluoride treatments; once in 90 days</li> <li>• Sealants; once per tooth in three years per provider or location (sealants over restored tooth surfaces not covered)</li> <li>• Space maintainers</li> </ul>	
<b>Group 2—Basic Restorative Services</b>		25% coinsurance after deductible
Fillings	<ul style="list-style-type: none"> <li>• Amalgam (silver) fillings; one filling per tooth surface in 12 months</li> <li>• Composite resin (white) fillings; one filling per tooth surface in 12 months</li> </ul>	

## Schedule of Dental Benefits (continued)

Covered Services		Your Cost Is:
<b>Group 2—Basic Restorative Services</b> (continued)		25% coinsurance after deductible
Root canal treatment	<ul style="list-style-type: none"> <li>• Root canals on permanent teeth; once per tooth</li> <li>• Vital pulpotomy</li> <li>• Retreatment of prior root canal on permanent teeth; once per tooth in 24 months</li> <li>• Root end surgery on permanent teeth; once per tooth</li> </ul>	
Crowns (see also Group 3)	<ul style="list-style-type: none"> <li>• Prefabricated stainless steel crowns; once per tooth (primary and permanent)</li> </ul>	
Gum treatment	<ul style="list-style-type: none"> <li>• Periodontal scaling and root planing; once per quadrant in 36 months</li> <li>• Periodontal surgery; once per quadrant in 36 months</li> </ul>	
Prosthetic maintenance	<ul style="list-style-type: none"> <li>• Repair of partial or complete dentures and bridges; once in 12 months</li> <li>• Reline or rebase partial or complete dentures; once in 24 months</li> <li>• Recementing of crowns, inlays, onlays, and fixed bridgework; once per tooth</li> </ul>	
Oral surgery	<ul style="list-style-type: none"> <li>• Simple tooth extractions; once per tooth</li> <li>• Erupted or exposed root removal; once per tooth</li> <li>• Surgical extractions; once per tooth (approval required for complete, boney impactions)</li> <li>• Other necessary oral surgery</li> </ul>	
Other necessary services	<ul style="list-style-type: none"> <li>• Dental care to relieve pain (palliative care)</li> <li>• General anesthesia for covered oral surgery</li> </ul>	
<b>Group 3—Major Restorative Services</b>		50% coinsurance after deductible
Crowns	<ul style="list-style-type: none"> <li>• Resin crowns; once per tooth in 60 months</li> <li>• Porcelain/ceramic crowns; once per tooth in 60 months</li> <li>• Porcelain fused to metal/high noble crowns; once per tooth in 60 months</li> </ul>	
Tooth replacement	<ul style="list-style-type: none"> <li>• Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 84 months</li> <li>• Fixed prosthetics, only if there is no other less expensive adequate dental service; once in 60 months</li> </ul>	
Other necessary services	<ul style="list-style-type: none"> <li>• Occlusal guards when necessary; once in calendar year</li> <li>• Fabrication of an athletic mouth guard</li> </ul>	
<b>Orthodontic Services</b>		50% coinsurance
Medically necessary orthodontic care that has been preauthorized for a qualified member	<ul style="list-style-type: none"> <li>• Braces for a member who has a severe and handicapping malocclusion</li> <li>• Related orthodontic services for a member who qualifies</li> </ul>	

# Dental Blue

## Pediatric Essential Benefits Plan

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This benefit booklet explains your pediatric essential dental benefits and the terms of your enrollment for these dental benefits. **This dental plan has a *Schedule of Dental Benefits* that includes the list of covered services and the cost-sharing amounts you must pay for covered services. It also describes the member age restriction to receive these dental benefits.** You should read all parts of this benefit booklet, including your *Schedule of Dental Benefits*, to become familiar with the key points. You should keep them handy so that you can refer to them. The words that are shown in italics have special meanings. These words are explained in Part 7 of this dental plan benefit booklet.

Blue Cross and Blue Shield of Massachusetts, Inc. (*Blue Cross and Blue Shield*) 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. *Blue Cross and Blue Shield* has entered into a contract with the *plan sponsor* on its own behalf and not as the agent of the Association.

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

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

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

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

**Haitian Creole/Kreyòl Ayisyen:** ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantifikasyon 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/عربي:**

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

**Mon-Khmer, Cambodian/ខ្មែរ:** ការជូនដំណឹង: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ 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.

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## Dental Blue Pediatric Essential Benefits Plan (continued)

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**Greek/λληνικά:** 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 شماره تلفن مندرج بروی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: 711).

**Lao/ພາສາລາວ:** ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: 711).

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

## Part 1 Dental Benefits

You will receive the dental benefits described in this dental plan benefit booklet and *Schedule of Dental Benefits* as long as:

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

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

### Obtaining Services from a Participating Dentist

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

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

- You have an emergency and a *participating dentist* is not reasonably available to you.
- You are outside Massachusetts and a *participating dentist* is not reasonably available to you.

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

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

### What You Pay for Covered Services

The cost-sharing amount you pay for a *covered service* (such as a *deductible* and/or *coinsurance*) is shown in your *Schedule of Dental Benefits*. It also describes the age restriction for a *member* to receive these dental benefits. Do not rely on this schedule alone. Be sure to read all parts of your dental plan benefit booklet to understand the requirements that you must follow to receive all of your dental benefits. You should also read the descriptions of *covered services* and the limitations and exclusions that apply for these dental benefits. These provisions are fully described in this benefit booklet.



### Pre-Treatment Estimates

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

### Multi-Stage Dental Procedures

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

### How Your Benefits Are Calculated

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

- **Participating dentists:** For *covered services* that are furnished by a dentist who has a payment arrangement to provide dental services to eligible *members* covered by this dental plan, *Blue Cross and Blue Shield* will calculate your benefits based on the provisions of the *participating dentist's* payment agreement and the contract rate that is in effect at the time the *covered service* is furnished. This contract rate is referred to as the dentist's *allowed charge*. **In most cases, you do not have to pay the amount of the *participating dentist's* actual charge that is in excess of the *allowed charge*.** But, there are certain times when you will have to pay the difference between the *allowed charge* and the *participating dentist's* actual charge (this is known as "*balance billing*"). You will have to pay this *balance bill* if any of the following situations happen: (1) you and your dentist decide to use a procedure that is more expensive than a less costly but approved alternative and *Blue Cross and Blue Shield* provides benefits toward the cost of the procedure with the lower fee; or (2) you could have received benefits or services from someone else without a charge or you have received or will receive payment from another person or insurance company until those benefits are used up; or (3) you receive services from more than one dentist for the same procedure or for procedures furnished in a series during a planned course of treatment and *Blue Cross and Blue Shield* has paid the amount that would have been provided had only one dentist furnished all of the services.
- **Non-participating dentists:** For *covered services* that are furnished by a non-*participating dentist*, *Blue Cross and Blue Shield* will calculate your dental benefits based on 80% of the *Blue Cross and Blue Shield* Maximum Allowable Charge for each specific *covered service*, but no more than 80% of the dentist's actual charge. The *allowed charge* is less than the dentist's actual charge. **You will be responsible for the amount of the dentist's actual charge that is in excess of the *allowed charge* (known as "*balance billing*").** You must pay this *balance bill* amount in addition to your cost-sharing amounts.

### Covered Services

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

### Excluded Services and Charges

No benefits are provided under this dental plan for:

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

## Dental Blue Pediatric Essential Benefits Plan (continued)

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

### Part 2 Member Services

#### How to Get Help for Questions

*Blue Cross and Blue Shield* can help you to understand the terms of your dental plan. You can call or write to the *Blue Cross and Blue Shield* customer service office. A *Blue Cross and Blue Shield* customer service representative will work with you to resolve your problem or concern as quickly as possible.

- **To call:** You can call Monday through Friday from 8:00 a.m. to 8:00 p.m. (Eastern Time). The toll free phone number to call is shown on your student health plan ID card. (For TTY, call 711.)
- **To write:** You can write to: Blue Cross Blue Shield of Massachusetts, Member Service, P.O. Box 9134, North Quincy, MA 02171-9134.

#### When You Need Help to Find a Participating Dentist

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

#### What to Do in an Emergency

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

#### Discrimination Is Against the Law

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

*Blue Cross and Blue Shield* provides:

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

If you need these services, call the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your student health plan 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](mailto:civilrightscoordinator@bcbsma.com). If you need help filing a grievance, the Civil Rights Coordinator is

## **Dental Blue Pediatric Essential Benefits Plan** (continued)

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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](http://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](http://www.hhs.gov).

### Part 3 Claims Filing Procedures

#### Filing a Claim

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

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

#### Timeliness of Claim Payments

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

### Part 4 Grievance Program

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

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

#### What to Do if You Have a Claim Problem or Complaint

Most problems or concerns can be handled with just one phone call. For help to resolve a problem or concern, you should first call the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your student health plan ID card. A customer service representative will work with you to help you understand your dental benefits or to resolve your problem or concern as quickly as possible. When resolving a problem or concern, *Blue Cross and Blue Shield* will consider all aspects of the particular case. This includes looking at: all of the provisions of this dental plan; the policies and procedures that support this dental plan; the dental provider's input; and your understanding and expectation of dental benefits. *Blue Cross and Blue Shield* will use every opportunity to be reasonable in finding a solution that makes sense for all parties. *Blue Cross and Blue Shield* will follow its standard guidelines when it resolves your problem or concern. If after speaking with a *Blue Cross and Blue Shield* customer service representative, you still disagree with the decision that is given to you, you may request a review through *Blue Cross and Blue Shield's* formal grievance program.

#### When and How to Request a Formal Grievance Review

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

- **To write or send a fax.** The preferred option is for you to send your grievance in writing to Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Or, you may fax your grievance to 1-617-246-3616.
- **To send an e-mail.** You may send your grievance by e-mail to *Blue Cross and Blue Shield* Member Grievance Program at [grievances@bcbsma.com](mailto:grievances@bcbsma.com). *Blue Cross and Blue Shield* will let you know that your request was received by sending you a confirmation immediately by e-mail.
- **To make a telephone call.** You may call the *Blue Cross and Blue Shield* Member Grievance Program at 1-800-472-2689.

Once your request is received, *Blue Cross and Blue Shield* will research the case in detail. They will ask for more information if it is needed. *Blue Cross and Blue Shield* will let you know in writing of the decision or the outcome of the review. All grievances must be received by *Blue Cross and Blue Shield* within one year of the date of treatment, event, or circumstance, such as the date you were told of the service denial or claim denial.

### **What to Include in a Grievance Review Request**

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

### **Authorized Representative**

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

### **Who Handles the Grievance Review**

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

### **Response Time**

The review and response for *Blue Cross and Blue Shield's* formal grievance review will be completed within 30 calendar days. If your grievance review begins after an inquiry, the 30-day response time will begin on the day you tell *Blue Cross and Blue Shield* that you disagree with *Blue Cross and Blue Shield's* answer and would like a formal grievance review. Every reasonable effort will be made to speed up the review of grievances that involve dental services that are soon to be obtained by the *member*. With your permission, *Blue Cross and Blue Shield* may extend the 30-calendar-day time frame to complete a grievance review. This will happen in those cases when *Blue Cross and Blue Shield* and the *member* agree that additional time is required to fully investigate and respond to the grievance. *Blue Cross and Blue Shield* may also extend the 30-calendar-day time frame when the grievance review requires a review of your medical or dental records and *Blue Cross and Blue Shield* requires your authorization to get these records. The 30-day response time will not include the days from when *Blue Cross and Blue Shield* sends you the authorization form to sign until it receives your signed authorization form (if needed). If *Blue Cross and Blue Shield* does not receive your authorization within 30 working days after your grievance is received, *Blue Cross and Blue Shield* may make a final decision about your grievance without that medical information. In any case, for a grievance review involving dental services that have not yet been obtained by you, *Blue Cross and Blue Shield* will ask for your permission to extend the 30-day time frame if it cannot complete the review within 30 calendar days of receipt of your grievance.

### **Written Response**

Once the grievance review is completed, *Blue Cross and Blue Shield* will let you know in writing of the decision or the outcome of the review. If *Blue Cross and Blue Shield* continues to deny benefits for all or part of a service, *Blue Cross and Blue Shield* will send an explanation to you. This notice will include: information related to the details of your grievance; the reasons that *Blue Cross and Blue Shield* has denied the request and the applicable terms of your dental plan; the specific medical and scientific reasons for



## Dental Blue Pediatric Essential Benefits Plan (continued)

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which *Blue Cross and Blue Shield* has denied the request; any alternative treatment or services and supplies that would be covered; and *Blue Cross and Blue Shield* clinical guidelines that apply and were used and any review criteria.

### Grievance Records

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

### Expedited Review for Immediate or Urgently-Needed Services

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

### Appeals Process for Rhode Island Residents or Services

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

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

The second step is an appeal. If *Blue Cross and Blue Shield* continues to deny benefits for all or a part of the service, you may ask for an appeal. You must ask for this appeal within 60 days of the date that you receive the reconsideration denial letter from *Blue Cross and Blue Shield*. Your appeal request should include any information that supports your appeal. You may also inspect and add information to your *Blue Cross and Blue Shield* case file to prepare your appeal. According to Rhode Island state law, if you wish to review the information in your *Blue Cross and Blue Shield* case file, you must make your request in writing and you must include the name of a dentist who may review your case file on your behalf. Your dentist may review, interpret, and disclose any or all of that information to you. Once *Blue Cross and Blue Shield* receives your appeal, your appeal will be reviewed by a dentist in the same specialty as your attending dentist. *Blue Cross and Blue Shield* will notify you of the outcome of your appeal within 15 calendar days after they have received all information needed for the appeal.

If your appeal is denied, you have the right to present your case to an appeals agency that is designated by Rhode Island and not affiliated with *Blue Cross and Blue Shield*. If you request this voluntary external appeal, Rhode Island requires that you pay for half of the cost of the appeal. *Blue Cross and Blue Shield* will pay for the remaining half. The notice you receive from *Blue Cross and Blue Shield* about your appeal

WORDS IN ITALICS ARE EXPLAINED IN PART 7.

## Dental Blue Pediatric Essential Benefits Plan (continued)

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will advise you of: the name of the appeals agency that is designated by Rhode Island; and your share of the cost for an external appeal. To file an external appeal, you must make your request in writing to: Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Along with your request, you must: state your reason(s) for why you disagree with *Blue Cross and Blue Shield's* decision; and enclose a check made payable to the designated appeals agency for your share of the cost for the external appeal. Within five working days after *Blue Cross and Blue Shield* receives your written request and payment for the appeal, *Blue Cross and Blue Shield* will forward your request to the external appeals agency. *Blue Cross and Blue Shield* will also send their part of the fee and your entire *Blue Cross and Blue Shield* case file. The external appeals agency will notify you in writing of the decision within ten working days of receiving all necessary information.

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

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

### Part 5 Other General Provisions

#### **Access to and Confidentiality of Dental and Medical Records**

*Blue Cross and Blue Shield* and health care and dental providers may, in accordance with applicable law, have access to all of your medical and dental records and related information that is needed by *Blue Cross and Blue Shield* or the health care or dental providers. *Blue Cross and Blue Shield* may collect information from health care and dental providers or from other insurance companies or from the *plan sponsor*. *Blue Cross and Blue Shield* will use this information to help them administer the benefits described in this dental plan. They will also use it to get facts on the quality of care that is provided under this and other health care and dental plans. In accordance with law, *Blue Cross and Blue Shield* and health care and dental providers may use this information, and may disclose it to necessary persons and entities as follows: (1) for administering benefits (including coordination of benefits with other insurance or health benefit plans), disease management programs, managing care, quality assurance, utilization management, the prescription drug history program, grievance and claims review activities, or other specific business, professional, or insurance functions for *Blue Cross and Blue Shield*; (2) for bona fide medical research according to the regulations of the U.S. Department of Health and Human Services and the U.S. Food and Drug Administration for the protection of human subjects; (3) as required by law or valid court order; (4) as required by government or regulatory agencies; (5) as required by the *subscriber's group* or by its auditors to make sure that *Blue Cross and Blue Shield* is administering this dental plan properly; and (6) for the purpose of processing claim, medical information may be required by your *group's* reinsurance carrier.

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

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

#### **Acts of Dentists**

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

#### **Assignment of Benefits**

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

### Authorized Representative

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

### Changes to this Dental Plan

*Blue Cross and Blue Shield* or the *plan sponsor* may change the provisions of this dental plan. For example, a change may be made to your cost-sharing amounts for certain *covered services*. The *plan sponsor* is responsible for sending you a notice of any change. The notice will describe the change being made. It will also give the effective date of the change. When a change is made to your dental plan, you can get the actual language of the change from your *plan sponsor*. The change will apply to all benefits for services you receive on or after its effective date.

### Coordination of Benefits (COB)

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

Under COB, the plan that provides benefits first is known as the primary payor. And the plan(s) that provide benefits next are known as the secondary payor(s). This dental plan is the secondary payor when another hospital, medical, dental, health or other plan provides benefits for dental services. This means that no dental benefits will be provided by this dental plan until after the primary payor determines its share, if any, of the liability.

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

### Pre-Existing Conditions

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

### **Quality Assurance Programs**

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

### **Subrogation and Reimbursement of Benefit Payments**

If you are injured by any act or omission of another person, the benefits provided under this dental plan will be subrogated. This means that *Blue Cross and Blue Shield*, as this dental plan's representative, 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, this dental plan is entitled to recover up to the amount of the benefit payments that it has made. This is true no matter where or by whom the recovered money is held or how it is designated and even if you do not recover the total amount of your claim against the other person(s). This is also true if the payment you receive is described as payment for other than dental expenses. The amount that you must reimburse to this dental plan will not be reduced by any attorney's fees or expenses that you incur. You must give *Blue Cross and Blue Shield*, as this dental plan's representative, information and help. This means you must complete and sign all necessary documents to help *Blue Cross and Blue Shield* get this money back on behalf of this dental plan. 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 this dental plan paid benefits. You must not do anything that might limit this dental plan's right to full reimbursement.

### **Time Limit for Legal Action**

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

### Part 6

## Eligibility and Termination Provisions

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

### Eligibility for Student Health Plan Coverage

#### Eligible Student

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

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

For more details, contact your *plan sponsor*.

#### Eligible Spouse

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

#### Former Spouse

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

#### Domestic Partner

As determined by the *group*, an enrolled eligible student may have the option to enroll an eligible domestic partner (instead of an eligible spouse) under his or her student health plan membership. For more details, contact your *plan sponsor*. In the event an enrolled student enrolls an eligible domestic partner under his or her student health plan membership, the domestic partner's dependent children are eligible for coverage to the same extent that the enrolled student's dependent children are eligible for coverage under his or her membership. If the enrolled student terminates the domestic partnership, the former domestic partner and any children of a former domestic partner are no longer eligible for coverage.

### Eligible Dependents

An eligible student who is enrolled in the *group's* student health plan may enroll eligible dependents under his or her student health plan membership. "Eligible dependents" include the enrolled student's (or his or her spouse's or, if applicable, domestic partner's) children 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 enrolled student or the enrolled student's spouse (or domestic partner), be a dependent on the enrolled student's or the spouse's (or domestic partner's) tax return, or be a full-time student. These eligible dependents may include:

- A newborn child. The effective date of coverage for a newborn child will be the child's date of birth provided that the enrolled student formally notifies the *group* within the time period required to make family status changes. (A claim for the enrolled *member's* maternity admission may be considered to be this notice when the enrolled student's coverage is a family plan.) The *group's* student health plan provides coverage for newborn infants for injury and sickness. This includes the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth. The coverage for these services is subject to all of the provisions of the *group's* student health plan.
- An adopted child. The effective date of coverage for an adopted child will be the date of placement with the enrolled student for the purpose of adoption. The effective date of coverage for an adoptive child who has been living with the enrolled student and for whom the enrolled student has been getting foster care payments will be the date the petition to adopt is filed. If the enrolled student is enrolled under a family plan as of the date he or she assumes custody of a child for the purpose of adoption, the child's health care services for injury or sickness will be covered from the date of custody. (This coverage is provided without a waiting period or pre-existing condition restriction.) This includes the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities and premature birth. The coverage for these services is subject to all of the provisions of the *group's* student health plan.

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

An eligible dependent may also include:

- A person under age 26 who is not the enrolled student's (or spouse's or, if applicable, domestic partner's) child but who qualifies as a dependent under the Internal Revenue Code.
- 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.
- A child recognized under a Medical Child Support Order as having the right to enroll for health care coverage.
- A disabled dependent child age 26 or older. A dependent child who is mentally or physically incapable of earning his or her own living and who is enrolled under the student's membership will continue to be covered after he or she would otherwise lose dependent eligibility for coverage under the enrolled student's membership, so long as the child continues to be mentally or physically incapable of earning his or her own living. In this case, the enrolled student must make arrangements with *Blue Cross and Blue Shield* through the *plan sponsor* within the time period required to make family status changes. Also, *Blue Cross and Blue Shield* must be given any medical or other information that it may need to determine if the child can maintain coverage in the *group's* student health plan under the enrolled student's membership. From time to time, *Blue Cross and Blue Shield* may conduct reviews that will require a statement from the attending physician. This is to confirm that the child is still an eligible disabled dependent child.

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

### **Membership Changes**

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

### **Termination of Coverage**

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

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

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

- The *group's* contract with *Blue Cross and Blue Shield* is terminated (or is not renewed).
- You commit misrepresentation or fraud to *Blue Cross and Blue Shield*. For example, you misused the ID card by letting another person not enrolled in the *group's* student health plan attempt to get coverage. Termination will go back to your effective date. Or, it will go back to the date of the misrepresentation or fraud, as determined by *Blue Cross and Blue Shield*, subject to applicable federal law. Or, in some cases *Blue Cross and Blue Shield* may limit your benefits.
- You commit acts of physical or verbal abuse that pose a threat to, or a threat to the health of, health care providers or other *members* or employees of *Blue Cross and Blue Shield* or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc., and these acts are not related to your physical condition or mental condition.
- You fail to comply in a material way with any provision of this dental plan. For example, if you fail to provide information that *Blue Cross and Blue Shield* requests related to your coverage in this dental plan, *Blue Cross and Blue Shield* may terminate your coverage.



### Part 7

## Explanation of Terms

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

### Allowed Charge (Allowed Amount)

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

### Balance Billing

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

### Blue Cross and Blue Shield

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

### Coinsurance

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

### Covered Services

The dental care covered by this dental plan. To be a *covered service* for benefits, each of the following conditions must be met:

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

### Deductible

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

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

### Group

The term “*group*” refers to the institution (or institute) of higher education that has entered into an agreement (a “contract”) under which *Blue Cross and Blue Shield* provides administrative services for the *group's* self-insured student health plan, which includes this dental plan.

### Member

A person who is enrolled and eligible for coverage under this dental plan. A *member* may be the *subscriber* (the enrolled student) or his or her enrolled eligible spouse or any other enrolled eligible dependent.

### Necessary and Appropriate

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

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

In some cases, *Blue Cross and Blue Shield* may review dental records describing your condition and treatment. *Blue Cross and Blue Shield* staff, including dental consultants, will review the treatment plan objectively and determine whether coverage is available under this dental plan, and whether these services are *necessary and appropriate* for you. Based on *Blue Cross and Blue Shield's* findings, *Blue Cross and Blue Shield* may determine that a service is not *necessary and appropriate* for you, even if your dentist has recommended, approved, prescribed, ordered, or furnished the service.

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

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

- The costs you pay for your dental plan.

## Dental Blue Pediatric Essential Benefits Plan (continued)

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

### Participating Dentist

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

### Plan Sponsor

The *plan sponsor* is the institution (or institute) of higher education that has entered into an agreement (a “contract”) under which *Blue Cross and Blue Shield* provides administrative services for the *group’s* self-insured student health plan.

### Plan Year

The period of time that may be used to calculate your *deductible* and *out-of-pocket maximum* amounts. It is the period of time that starts on the original *effective date* of your *group’s* student health plan coverage and continues for 12 consecutive months or until your *group’s* renewal date, whichever comes first. A new *plan year* begins each 12-month period thereafter. If you do not know when your *plan year* begins, you can ask your *plan sponsor*.

### Rider

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

### Schedule of Dental Benefits

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

### Subscriber

The *subscriber* is the eligible student who signs the enrollment form at the time of enrollment in the *group’s* student health plan.

### Utilization Review

The review process that *Blue Cross and Blue Shield* uses to evaluate the *necessity and appropriateness* of a dental service. To do this, *Blue Cross and Blue Shield* uses clinical guidelines and *utilization review* criteria that are designed to monitor the use of, or evaluate the clinical necessity and appropriateness of the service. This process is designed to encourage appropriate care, not less care. To develop its clinical guidelines and *utilization review* criteria, *Blue Cross and Blue Shield* assesses each service to determine that it is: consistent with the prevention and treatment of tooth decay and other forms of oral disease, or

## Dental Blue Pediatric Essential Benefits Plan (continued)

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with the treatment of teeth that are decayed or fractured or where the supporting structure is weakened by disease; consistent with standards of good dental practice; and as cost effective as any established alternative. Periodically, *Blue Cross and Blue Shield* reviews its policies, clinical guidelines, and review criteria to reflect new treatments, applications, and technologies.

## Dental Blue Pediatric Essential Benefits Plan (continued)

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