

Dental Blue[®] Program 1

A Dental Plan administered by
Blue Cross and Blue Shield of Massachusetts, Inc.

Benefit Description

Welcome to Dental Blue

This booklet provides you with a description of your benefits while you are enrolled under the Dental Blue plan offered by your *plan sponsor*. You should read this booklet to familiarize yourself with this dental plan's main provisions and keep it handy for reference.

Blue Cross and Blue Shield has been designated by your *plan sponsor* to provide administrative services to this dental plan, such as claims processing, case management and other services, and to arrange for a network of dentists whose services are covered by this dental plan. The *Blue Cross and Blue Shield* customer service office can help you understand the terms of this dental plan and what you need to do to get your maximum benefits.

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.

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 مجاناً بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (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 निःशुल्क 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 بروی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: **711**).

Lao/ພາສາລາວ: ຂໍຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາຜ່ານບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yáníłt'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'ígíijí' béésh bee hodíílnih (TTY: **711**).

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Introduction

You are covered under this Dental Blue plan. This dental plan is a non-insured self-funded benefits plan and is financed by contributions by your *group* and its enrolled employees. For details concerning your *group's* contributions, contact your *plan sponsor*.

An organization has been designated by your *plan sponsor* to provide administrative services to this dental plan, such as claims processing, case management and other services, and to arrange for a network of dentists whose services are covered by this dental plan. The name and address of this organization is: Blue Cross and Blue Shield of Massachusetts, Inc., 101 Huntington Avenue, Suite 1300, Boston, Massachusetts 02199-7611.

These benefits are provided by your *group* on a self-funded basis. *Blue Cross and Blue Shield* is not an underwriter or insurer of the benefits provided by this dental plan.

This booklet along with all *riders* that are part of your dental plan provide you with a description of your benefits while you are enrolled in this dental plan. You should read this booklet 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. *Blue Cross and Blue Shield* or your *group* may change the terms of this dental plan. If this is the case, the change is described in a *rider*. Your *plan sponsor* can supply you with any *riders* that apply to your benefits.

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 Benefit Description, the term “you” refers to any *member* who has the right to the benefits provided under this dental plan—the *subscriber* or the enrolled spouse or any other enrolled dependent.

Member Services

Identification Cards

When you enroll for benefits under this dental plan, 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.org.

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.org. 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.org. 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 dental plan 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

Member Services (continued)

understand your benefits or resolve your problem or concern as quickly as possible. (See Part 7 for more information about 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.

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 Benefit Description and in any *riders* that apply to your benefits under this dental plan. These terms will give you a better understanding of your dental 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. This dental plan 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., the organization that has been designated by your *plan sponsor* to provide administrative services to this dental plan, such as claims processing, case management and other services, and to arrange for a network of dentists whose services are covered by this dental plan. This includes an employee or designee of *Blue Cross and Blue Shield* who is authorized to make decisions

Part 1 – **Definitions** (continued)

or take action called for as described in this Benefit Description. *Blue Cross and Blue Shield* has full discretionary authority to interpret this Benefit Description. 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 Benefit Description. 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.

Covered Services

The dental services, supplies, procedures and appliances for which this dental plan provides benefits as described in this Benefit Description and any *riders* to this Benefit Description. (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 dental plan. (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 Benefit Description 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.

Effective Date

The date on which your membership in this dental plan starts.

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 entered in to an agreement under which *Blue Cross and Blue Shield* provides administrative services for the *group's* self-insured dental benefits plan.

Member

You, the person who has the right to the benefits described in this Benefit Description. 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).

WORDS IN ITALICS ARE EXPLAINED IN PART 1.

Part 1 – **Definitions** (continued)

- 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.

Under certain circumstances, *Blue Cross and Blue Shield* may review 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 may review the treatment plan objectively and determine 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 plan. 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.

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 Benefit Description. *Blue Cross and Blue Shield* or your *group* may change the terms of your dental plan. For example, a *rider* may add or limit the benefits provided under this dental plan. A *rider* describes the material change that is made to your dental plan. You should keep any *riders* with your Benefit Description.

Subscriber

The eligible person who signs the enrollment form at the time of enrollment under this dental plan.

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

This dental plan provides benefits for the *covered services* described in this Benefit Description 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 Benefit Description 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 Benefit Description 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 Dental Blue plan to another, any dollar amount applied toward your calendar-year maximum under prior Dental Blue plans will be carried over and applied to the calendar-year maximum under this dental plan.)

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 Benefit Description.

Preventive Benefit Group (Group 1 Services)

This dental plan 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), twice each calendar year.
- 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, twice each calendar year.

Preventive Services

- Routine cleaning, scaling and polishing of the teeth, twice each calendar year.
- Fluoride treatment for *members* under age 19, twice each calendar year.
- 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. This dental plan provides benefits for one application each 48 months for each premolar or molar surface.

Basic Benefit Group (Group 2 Services)

This dental plan 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 relined 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.) This dental plan provides benefits for amalgam (silver) fillings toward the cost of composite resin (tooth color) fillings on back teeth (bicuspid 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.

Part 3 – Covered Services (continued)

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 dental plan 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 Benefit Description. If you have these benefits, your *plan sponsor* will supply you with the Orthodontic Endorsement that applies to your benefits for orthodontic services at the time you enroll for benefits under this dental plan. Also, if a change is made to your benefits for orthodontic services, your *plan sponsor* 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

Part 3 – **Covered Services** (continued)

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 Benefit Description 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 dental plan on the date the procedure is completed. This means that you do not have to be enrolled under this dental plan on the date the procedure is started in order to receive benefits for the *covered service*. However, if your membership under this dental plan 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 Benefit Description.
- A service, supply, procedure or appliance that is not described as a *covered service* in this Benefit Description.
- 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, this dental plan 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.

WORDS IN ITALICS ARE EXPLAINED IN PART 2.

Part 4 – Limitations and Exclusions (continued)

- 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 dental plan.
- 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 dental plan. (Remember; if your membership under this dental plan 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,

WORDS IN ITALICS ARE EXPLAINED IN PART 1.

Part 4 – Limitations and Exclusions (continued)

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 dental plan 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 Benefit Description. This means that your dental services will be covered from the *effective date* of your membership under this dental plan without a pre-existing condition restriction. No benefits will be provided under this dental plan 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 dental plan 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 in this dental plan, 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 dental plan 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 the COB regulations issued by the Massachusetts Division of Insurance (see the COB rules described below). To the extent state law does not govern this dental plan, however, state law will not limit *Blue Cross and Blue Shield's* discretion to determine which is the primary and secondary payor. For example, this dental plan is not subject to Massachusetts requirements concerning coordination between no-fault automobile personal injury protection (PIP) and health insurance, and if PIP is available, this dental plan will not pay benefits until PIP is exhausted.

This dental plan will not provide any more benefits than those already described in this Benefit Description. This dental plan will not provide duplicate benefits for covered services. If this dental plan pays more than the amount that it should have under COB, then you must give that amount back to *Blue Cross and Blue Shield* on behalf of this dental plan. This dental plan 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.

COB Rules to Determine the Order of Benefits

When other plan(s) under which you are covered include COB rules consistent with the COB rules described in this section, *Blue Cross and Blue Shield* will decide which plan is the primary payor and the secondary payor based on these COB rules. However, if another plan under which you are covered does not include COB rules consistent with the COB rules described below, that plan will determine benefits before this dental plan.

- **Employee/Dependent Rule.** The plan that covers the person who is claiming benefits as an employee (the *subscriber*) will determine benefits before a plan under which that person is covered as a dependent.

Part 5 – Other Party Liability (continued)

- **Children of Parents Who Are Not Separated or Divorced (“Birthday Rule”).** When the person who is claiming benefits is covered under two or more plans as a dependent child of parents who are not separated or divorced, the plan of the parent whose birthday falls earlier in a year will determine benefits before the plan of the parent whose birthday falls later in the year. This is referred to as the “birthday rule.” This refers only to the month and day in a calendar year, not the year in which the parent was born. However, if both parents have the same birthday, the plan that has covered a parent the longest will determine benefits before the plan that has covered a parent for a shorter period of time. (If another plan does not include the “birthday rule” described in this section, but instead includes a rule based on the gender of the parent and as a result, if the plans do not agree on the order of benefits, the “birthday rule” will be used to determine the order of benefits.)
- **Children of Separated or Divorced Parents.** When the person who is claiming benefits is a covered child of parents who are separated or divorced, unless there is a court order that requires one parent to be responsible for health care coverage, the order used to determine benefits will be: (1) the plan of the parent who has custody of the child will determine benefits before the plan of the parent who does not have custody of the child; (2) the plan of the spouse of the parent who has custody will determine benefits before the plan of the parent who does not have custody of the child; and then (3) the plan of the parent who does not have custody of the child.

If there is a court decree that states that one of the parents is responsible for health care expenses of the child, the plan covering that parent will determine benefits first, provided that the plan has knowledge of the terms of the court decree. If a court decree grants joint custody but does not state that one parent is responsible for the child’s health care expenses, the “birthday rule” described above will be used to determine the order of benefits.

- **Active/Inactive Employee Status.** The plan that covers the person who is claiming benefits as an active employee (or as a dependent of that employee) will determine benefits before a plan under which that person is covered as a laid-off or retired employee (or as a dependent of that employee). If another plan does not include this COB rule and if, as a result the plans do not agree on the order of benefits, this COB rule will not be used to determine the order of benefits.
- **Plans With the Earlier Effective Date.** If none of the previous COB rules determine the order of benefits, the plan that has covered the person who is claiming benefits longer will be determined before the plan that has covered the person who is claiming benefits for a shorter period of time.

If other plan(s) under which you are covered do not include COB rules consistent with the COB rules described in this section, that plan will determine benefits before this dental plan.

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 this dental plan will be reduced by the amount of benefits allowed under Medicare for the same *covered services*. This reduction will be made whether or not you actually receive the benefits from Medicare.

Plan 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 dental plan will be subrogated. This means that this dental plan and *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

Part 5 – **Other Party Liability** (continued)

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 health care expenses. The amount you must reimburse this dental plan will not be reduced by any attorney's fees or expenses you incur.

Member Cooperation

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 the 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.

Workers' Compensation

No benefits are provided for health care services and supplies to treat an illness or injury for which you have the right to benefits under any workers' compensation act or equivalent employer liability or indemnification law. All employers provide their employees with workers' compensation insurance. This is done to protect employees in case of work related illness or injury. All dental claims related to the illness or injury must be billed to the employer's workers' compensation carrier. It is up to you to use workers' compensation insurance. If this dental plan provides or pays for *covered services* that are covered by workers' compensation, *Blue Cross and Blue Shield* on behalf of this dental plan has the right to get paid back from the party that legally must pay for the health care services.

If you have recovered the value of services from workers' compensation or another employer liability program, you will have to pay the amount recovered for dental services that were paid by this dental plan. If *Blue Cross and Blue Shield* is billed in error for these services, you must promptly call or write the *Blue Cross and Blue Shield* 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. The dentist will be paid 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*. This dental plan will not have to provide benefits for 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, 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 Benefit Description. 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 this dental plan 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 dental plan, *Blue Cross and Blue Shield* has full discretionary authority to interpret this Benefit Description and to determine whether a dental service is a covered service under this dental plan. 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.

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.

When resolving a problem or concern, *Blue Cross and Blue Shield* will consider all aspects of the particular case, including the terms of your *group* benefits as described in this Benefit Description, *Blue Cross and Blue Shield* policies and procedures that support the administration of these benefits, the dentist'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, you may request a review through the formal internal grievance program as described below. 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

Internal Formal Grievance Review

How to Request a Grievance Review

To request a formal review from the internal 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.

Part 7 – **Grievance Program** (continued)

- Or, you may send your grievance to the 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 the 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 and ask for more information as needed. When the review is completed, *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 name and dental plan 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; details of the attempt that has been made to resolve the problem; and any comments, documents, records and other information to support your grievance. 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 may have been 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 internal 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

Part 7 – **Grievance Program** (continued)

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.

Response

Once the grievance review is completed, *Blue Cross and Blue Shield* will let you know 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 and information about requesting an external review.

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 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. 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.

External Review

For all grievances, you must first go through the formal internal grievance process as described above. In some cases, you are then entitled to a voluntary external review. *Blue Cross and Blue Shield's* grievance review may deny coverage for all or part of a health care service or supply. When the denial is because *Blue Cross and Blue Shield* has determined that the service or supply is not *necessary and appropriate*, you have the right to an external review. You are not required to pursue an external review and your decision whether to pursue it will not affect your other benefits. If you receive a denial letter from *Blue Cross and Blue Shield* for this reason, the letter will tell you what steps you should take to file a request for an external review. A decision will be provided within ten days of the date the external reviewer receives your request for a review.

You also have the right to an expedited external review. You may request an expedited external review by contacting *Blue Cross and Blue Shield* at the telephone number shown in your denial letter. A final decision will be provided within 72 hours after the external reviewer receives your request for a review.

Part 7 – **Grievance Program** (continued)

You must file your request for an external review or expedited external review within 30 days of receiving the denial letter sent to you by *Blue Cross and Blue Shield* following the formal internal grievance process. *Blue Cross and Blue Shield* will work closely with you to guide you through the external review or expedited external review process.

Part 8

Other Plan 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 Benefit Description 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.
- For the purpose of processing a claim, dental or medical information may be released to your *group's* reinsurance carrier.

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.

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 dental plan to any person, corporation or other organization without the *plan sponsor's* and *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 dental plan 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 Dental Plan

The *plan sponsor* or *Blue Cross and Blue Shield* may change the benefits described in this Benefit Description. For example, a change may be made to the amount you must pay for certain 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 benefits, 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.

Services Furnished by Non-Participating Dentists

Covered Services Furnished In Massachusetts

The benefits described in this Benefit Description are provided only when *covered services* are furnished by a *participating dentist*. There is one exception to this requirement. This dental plan will provide benefits for *covered services* furnished in Massachusetts by *non-participating dentists* but **only** when you receive *covered services* that are furnished in an emergency and a *participating dentist* is not reasonably available. You will have to pay the difference between the claim payment and the dentist's actual charge for *covered services*.

Part 8 – Other Plan Provisions (continued)

Covered Services Furnished Outside Massachusetts

The benefits described in this Benefit Description 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 a formal internal grievance review (see Part 7). You may, but do not need to, pursue an external review prior to pursuing a legal action. 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 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 you were first sent a notice of the service or claim denial. Going through the internal formal grievance process does not extend the two-year limit for filing a lawsuit. However, if you choose to pursue a voluntary external review, the days from the date your request is received by the external reviewer until the date you receive the response are not counted toward the two-year limit.

Part 9

Eligibility for Coverage

Who Is Eligible to Enroll

Eligible Employee

An employee is eligible to enroll as a *subscriber* under this dental plan 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 dental plan. An “eligible spouse” includes the *subscriber’s* legal spouse. (A legal civil union spouse, where applicable, is eligible to enroll under this dental plan 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 dental plan. This coverage is provided with no additional cost. 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 under his or her membership under this dental plan. “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.

Part 9 – Eligibility for Coverage (continued)

- 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.
- 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 dental plan 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 dental plan 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 dental plan 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 dental plan.

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.

WORDS IN ITALICS ARE EXPLAINED IN PART 1.

Part 9 – **Eligibility for Coverage** (continued)

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 Benefit Description.

Part 10

Termination of Coverage

You do not have to worry that your membership in this dental plan will be canceled because you are using your benefits or because you will need more *covered services* in the future. Your membership in this dental plan will be canceled **only when**:

- The *subscriber* chooses to cancel his or her contract as permitted by the *plan sponsor*. The *subscriber* may do so at any time for any reason by sending a written notice to the *plan sponsor*. *Blue Cross and Blue Shield* must receive the termination request from the *plan sponsor* not more than 30 days after the *subscriber's* termination date.
- 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 dental plan.
- 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 dental plan will be the date on which eligibility is lost.
- The *subscriber* dies.
- 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 dental plan 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.
- The *subscriber's group* terminates (or does not renew) this dental plan.

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

Part 11

Continuation of Coverage

Family and Medical Leave Act

An employee may continue membership in this dental plan 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 dental plan 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 in this dental plan 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 this dental plan 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.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

When you are no longer eligible for membership in this dental plan, you may be eligible to continue this coverage as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA). 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 the divorce judgment 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 COBRA 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 COBRA coverage begins with the date of your qualifying event. And, the length of this continued COBRA 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 COBRA 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 dental plan, 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 dental plan.

Additional COBRA Coverage for Disabled Employees

Within 60 days of the qualifying event, 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 in this dental plan as a result of a bankruptcy proceeding (Title 11 of the United States Code) is also eligible for continued COBRA coverage. A retired employee and/or the surviving spouse of a deceased retired employee may enroll for lifetime COBRA 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 COBRA coverage as of the date *group* eligibility is lost. Spouses and/or eligible dependent children of these retired employees may enroll for continued COBRA 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 COBRA coverage beyond the date of the retired employee's death. (Lifetime COBRA coverage for retired employees will end if this dental plan is terminated by the *plan sponsor* or for any of the other reasons described below. See "Termination of Continued Coverage.")

Enrollment for COBRA Coverage

In order to enroll for continued coverage in this dental plan, you must complete a COBRA 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 COBRA 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 in this dental plan. (The 60 days will be counted from the date of the COBRA eligibility notice to the postmarked date of the mailed election form.)

Termination of COBRA Continued Coverage

Your COBRA 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 COBRA 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 dental plan will end when the *group* terminates its agreement with *Blue Cross and Blue Shield* to provide the coverage described in this Benefit Description.

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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