





Blue Cross Blue Shield Blue Care Network of Michigan

Confidence comes with every card.®

BLUE DENTAL℠ INDIVIDUAL MARKET BENEFITS CERTIFICATE

Blue Cross Blue Shield of Michigan 10-Day Money-Back Guarantee

Blue Cross Blue Shield of Michigan is committed to the health and satisfaction of our members. If for any reason you are unsatisfied and wish to terminate your coverage, simply notify BCBSM in writing within 10 days after the effective date of your coverage. You will receive a full refund of your premium. If you terminate your coverage after it has been effective for 10 days, you will receive a pro-rated refund on the unused portion of your premium. Please see Section 9 of this certificate for our mailing address and Dental Customer Service telephone numbers.

This contract is between you and Blue Cross Blue Shield of Michigan. Because we are an independent corporation licensed by the Blue Cross and Blue Shield Association – an association of independent Blue Cross and Blue Shield plans – we are allowed to use the Blue Cross and Blue Shield names and service marks in the state of Michigan. However, we are not an agent of BCBSA and, by accepting this contract, you agree that you made this contract based only on what you were told by BCBSM or its agents. Only BCBSM has an obligation to provide benefits under this certificate and no other obligations are created or implied by this language.

Dear Subscriber

This Blue Cross Blue Shield of Michigan (BCBSM) dental coverage is designed to help you and your eligible dependents maintain healthy smiles. Because dentists are often the first healthcare professionals to identify signs of serious health conditions in their patients, using your Blue Dental[SM] benefits could help you improve your overall health, too.

We encourage you to use your Blue Dental benefits. This certificate, along with any riders that amend it, will help you better understand these benefits. If you have questions about this coverage, please call us at 1-888-826-8152 or check our website at http://www.bcbsm.com/.

This certificate, your signed application and your BCBSM identification card are your contract with us.

We're pleased that you're a Blue Dental subscriber, and we look forward to serving you for many years.

Sincerely,

Daniel J. Loepp
President and Chief Executive Officer
Blue Cross Blue Shield of Michigan

About Your Certificate

This certificate is arranged to help you locate information easily. You will find:

- **A Table of Contents** – for quick reference
- **Information About Your Contract**
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- **How Dental Benefits Are Paid**
- **General Conditions of Your Contract**
- **Definitions** – explanations of the terms used in your certificate
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This certificate provides you with the information you need to get the most from your Blue Dental coverage.

If you have any questions, please call Dental Customer Service at: **1-888-826-8152**.
Business hours: Monday through Friday from 8 a.m. to 7 p.m. Eastern Time.

Please have your Blues ID card with your group and enrollee ID numbers ready when you call us.

Your certificate refers to you as the **subscriber** because the contract is in your name.

The term **member** refers to either you or one of your eligible dependents who receive dental services. Your eligible dependents are those listed on your application.

Table of Contents

Section 1: Information About Your Contract

This section provides answers to general questions you may have about your contract. Topics include:

- **ELIGIBILITY**
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- **WHEN YOU CAN ENROLL**
- **WHEN YOUR BENEFITS BEGIN**
- **CHANGING YOUR COVERAGE**
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ELIGIBILITY

You will need to complete an application for coverage.

We will review your application to determine if you and the people you list on it are eligible. Our decision will be based on the eligibility rules in this certificate and our underwriting policies.

If you or anyone applying for coverage on your behalf commits fraud or intentionally lies about a material fact when filling out your application, your coverage may be rescinded. See "*Rescission*" on page 7.

If you or anyone applying for coverage on your behalf lies about your state or county of residence, we have the right to get back from you the difference in premium from what you are paying and what you should have paid.

Who Is Eligible for Individual Coverage

You, your spouse and the children you have listed on your application are eligible if:

- You are a resident of Michigan and a U.S. citizen or legally present and live in the state at least 180 days a year

Who Is Eligible to Receive Benefits

- You
- Dependents listed on your contract:
  - Your spouse
  - Your children

Children listed on your contract are covered through the end of the calendar year in which they turn age 26 as long as you are covered under this certificate. The children must be related to you by:

- Birth
- Marriage
- Legal adoption or
- Legal guardianship

Children must be Michigan residents, unless they live somewhere else temporarily (as in the case of college students).

Your child's spouse and your grandchildren are not eligible for coverage under this certificate.

Who is Eligible to Receive Benefits (continued)

After the end of the year in which your child turns 26, the child must have their own contract. If a dependent cannot be covered by your contract anymore, they may be able to get their own.

Some benefits change based on the member's age. Please see the *Coverage for Dental Services* section to determine what benefits apply to you and your dependent children.

If this certificate or a Blue Dental rider states we will pay for a service for members age 19 and older, we will pay for it only for members who are age 19 or older on the date their coverage begins for the given calendar year. Members who are age 18 or younger on the date their coverage takes effect are not eligible for these services until the beginning of the calendar year after they have turned 19.

Disabled Unmarried Children

Disabled, unmarried children may remain covered after they turn age 26 if all the following apply:

- They cannot support themselves due to a diagnosis of:
  - A physical disability or
  - A developmental disability
- They depend on you for support and maintenance

You must send us a physician's certification proving the child's disability. We must receive it 31 days after the end of the year in which the child turns age 26. We will decide if the child meets the requirements.

A dependent or spouse who becomes ineligible for coverage under this contract may be eligible for their own contract. However, we must be notified within 60 days of the date the person becomes ineligible to provide special enrollment of this person. They may enroll in other dental coverage as long as it is within 60 days of the date this coverage ends or during the annual open enrollment period.

WHEN YOU CAN ENROLL

- If you purchased coverage **on** the Marketplace, you can enroll:
  - During the annual open enrollment period
  - Up to 60 days after a qualifying event
  - At other times of the year as allowed by federal law
- If you purchased coverage **off** the Marketplace, you can enroll:
  - During the annual open enrollment period
  - At any time during the calendar year; this coverage does not require a qualifying event for enrollment.

If this coverage is terminated, you will not be allowed to re-enroll in Blue Dental or Blue Dental with Adult Vision for three years.

WHEN YOUR BENEFITS BEGIN

Unless your plan has a waiting period, covered benefits and services are available on the effective date of your contract.

CHANGING YOUR COVERAGE

You may change your coverage only during the annual open enrollment period or at other times of the year as allowed by federal law.

You may change who may receive benefits under your current coverage if there is a qualifying event, including, but not limited to:

- Birth
- Adoption
- Marriage
- Divorce
- Death of a member
- Start or end of military service

If you purchased this coverage **on** the Health Insurance Marketplace (Marketplace), you must notify the Marketplace within 60 days of the change. You generally have up to 60 days after the event to make a new plan selection. The date of this change is set by federal law.

Changing Your Coverage (continued)

If you purchased this coverage **off** the Marketplace, we must receive notice from you within 60 days of when a dependent or spouse is removed from coverage, and within 60 days of when a dependent or spouse is added. The date of the change and contract change effective dates are set by federal law. Not all effective dates are assigned the date of the event. The effective date depends on the type of event and options allowable by law.

You may add a member to your current coverage if you have a qualifying event. Generally, children must be added to your current coverage within 60 days of birth or adoption. Other dependents must be added to your coverage within the time allowed under federal law.

You must remove a member from your plan, as in the case of a divorce, within 60 days of the date of divorce. You may not change your coverage when you remove a member from your current plan, except as established by federal law. The member may qualify for their own coverage due to the qualifying event.

If a member on this contract dies, please notify us, and your rate will be adjusted as of the date of death. If the subscriber dies, the contract must be rewritten to reflect a new subscriber and the rate will be adjusted. In either event, you may not change your coverage until the next open enrollment period, except as established by federal law.

If you are changing your coverage in any of these ways, you must provide supporting proof of your qualifying event. For a list of supporting proof by event, please visit https://www.bcbsm.com/documents.html.

Once you receive your new ID card, do not use your old one. However, keep your old card until all claims incurred under your former dental policy or contract have been processed.

TERMINATION

How to Terminate Your Coverage

We will accept termination of your coverage only from you. Your coverage will be terminated and all benefits under this certificate will end. A refund or credit will be given for the pro-rated share of any premiums that were prepaid.

If you voluntarily terminate your coverage and premium is due, BCBSM reserves the right to collect this premium from you. You may not be able to enroll in a dental product until the next annual open enrollment or unless you experience a qualifying event.

If you purchased this coverage **on** the Marketplace, you may terminate it only if you contact the Marketplace with proper notice. Once you provide this notice, the Marketplace will notify us of the date the termination takes effect, which is usually 14 days from the date of notification.

If you purchased this coverage **off** the Marketplace, call or send us your written request to terminate coverage at the phone number or address listed in Section 9. You may also call the phone number on your BCBSM identification card.

If you decide to terminate your coverage within 10 days after the date that it is effective, you will be given a full refund of the premium that you paid. If you decide to terminate your coverage after it has been effective for 10 days, you will be given a pro-rated refund of any unused portion of the premium that you paid.

How We Terminate Your Coverage

We may terminate this coverage if:

- You are no longer eligible for coverage under this certificate
- You do not pay your bill on time
- You are serving a criminal sentence for defrauding BCBSM
- You cannot provide proof you live in Michigan at least 180 days a year
- We no longer offer this coverage
- You **misuse** your coverage

  Misuse includes illegal or improper use of your coverage such as:

  - Allowing an ineligible person to use this coverage
  - Requesting payment for services that were not received

How We Terminate Your Coverage (continued)

- You fail to repay BCBSM for payments we made for services that were not a benefit under this certificate, subject to your rights under the appeals process
- You are satisfying a civil judgment in a case involving BCBSM
- You are repaying BCBSM funds you received illegally
- You no longer qualify as a member or dependent

Your coverage will end on the last day covered by your last premium payment. If a child is no longer eligible for coverage because of age, coverage for that child will end on the last day of the year in which the child turns 26.

If we terminate your coverage, we will provide you with 30 days' notice, along with the reason for the termination.

Rescission

We will rescind your coverage if you or someone seeking coverage on your behalf has:

- Performed an act, practice or omission that constitutes fraud, or
- Intentionally lied about a material fact to BCBSM or another party, which results in you or a dependent obtaining or retaining this coverage with BCBSM, or the payment of claims under this or another BCBSM certificate.

We may rescind this coverage back to the effective date of this contract. If we do, we will provide you with a 30-day notice. Once we notify you that we are rescinding this coverage, we may hold or reject claims during this 30-day period. You must repay BCBSM for its payment for any services you received.

BILLING

Information About Your Bill

Each bill for a regular billing cycle covers a one-month period.

If you purchased this coverage **on** the Health Insurance Marketplace (Marketplace) and the Marketplace determines you are eligible for a premium tax credit (subsidy):

- You are responsible only for your portion of the premium, not any applicable amount covered by the subsidy.
- You must pay your premium by the due date printed on your bill. When we receive your payment, we will continue your coverage through the period for which you have paid.

Information About Your Bill (continued)

- You may get subsidies only if:
  - This coverage is available on the Marketplace and
  - You buy this coverage on the Marketplace

If you are receiving an advance payment of a federal premium tax credit and have paid at least one full month of premium during the current benefit year, you will be given a three-month grace period before we will terminate or cancel your coverage for not paying your premium when due. If you receive dental services at any time during the second and third months of the grace period, we will hold payment for claims for these services beginning on the first day of the second month of the grace period. We will notify your providers that we are not paying these claims during this time.

If we do not receive your payment in full for all premiums due before the grace period ends, your coverage will be terminated or cancelled. Your last day of coverage will be the last day of the first month of the three-month grace period. All claims for any dental services that were provided after that last day of coverage will be denied.

If you purchased this coverage either **on** or **off** the Marketplace, but are not eligible for a subsidy:

- You are responsible for the entire premium amount.
- You must pay your premium by the due date printed on your bill. When we receive your payment, we will continue your coverage through the period for which you have paid.
- The three-month grace period does not apply if you do not receive a premium tax credit. If we do not receive your premium by the due date, we will allow you a grace period of 31 days, during which we will send you a final bill. If we do not receive your premium payment during the grace period, your coverage will be terminated or cancelled as of the last day of paid coverage.

We will accept payment of your dental insurance premium only from you, your spouse, or when appropriate, from a parent, blood relative, legal guardian or other person or entity that is allowed by law to pay your premium on your behalf.

How Rates Are Classified

Your rate will be based upon certain rating factors such as age and where you live, in accordance with federal law.

Section 2: What You Must Pay

You may have to pay a deductible and/or coinsurance for covered dental services. A rider that amends this certificate explains what cost sharing you must pay.

Deductible Requirements

The deductible (if any) is the amount you must pay for covered services each calendar year before we pay for services. A rider that amends this certificate will tell you if you have a deductible or a family limit on your deductible and how much it will be.

We will not apply payments toward your deductible if one of the following applies:

- The payment is for a charge that exceeds our approved amount.
- The payment is for a non-covered service.

Coinsurance Requirements

Coinsurance (if any) is the portion of the approved amount that you must pay for covered services. A rider will indicate if you must pay coinsurance.

We will not apply a coinsurance to:

- The difference between our approved amount and the dentist's charge.
- Non-covered services.

Annual Benefit Maximum

Your coverage includes an annual benefit maximum. A rider will show the maximum amount we will pay per member for covered services provided in each calendar year. The annual maximum is separate for each person covered on your contract and does not apply to pediatric members.

Out-of-Pocket Maximum

This is the maximum out-of-pocket cost you will pay in a calendar year for deductible and coinsurances that are required for covered dental services provided by PPO (in-network) dentists to pediatric members. Only cost sharing you pay for covered services provided by PPO (in-network) dentists will apply to the out-of-pocket maximum. After this out-of-pocket maximum has been reached, you will not pay any more deductibles or coinsurances for PPO (in-network) services provided to pediatric members for the remainder of the calendar year.

We will not apply payments toward your out-of-pocket maximum that:

- Are for services provided by non-PPO (out-of-network) dentists
- Exceed our approved amount
- Are for non-covered services

Section 3: Coverage for Dental Services

This section describes the services we pay for and the extent to which they are covered. We pay for services when they are provided according to this certificate and any riders that amend it.

- To be covered, services must be:
  - Dentally necessary and
  - Performed by a dentist, or, where applicable,
  - Performed by a dental hygienist under the supervision of a dentist.

See Section 4 for any exclusions and limitations.

Class I – Diagnostic and Preventive Services

- **Diagnostic and preventive services** – evaluate existing conditions, prevent oral disease, and stop the progress of disease already present. These services include:
  - Oral examinations/evaluations
  - Prophylaxes
  - Fluoride treatments
- **Bitewing radiographs (X-rays) and individual periapical films** – as needed for routine care or to detect specific conditions.
- **Oral brush biopsy sample collection** – identifies cancerous and precancerous cells.

Class II – Basic Services

- **Other diagnostic and preventive services:**
  - Diagnostic tests and laboratory examinations
  - Dental sealants
  - Space maintainers
- **Full-mouth and panoramic radiographs (X-rays).**
- **Emergency palliative treatment** – provides temporary pain relief.
- **Minor restorative services** – repair decayed or damaged teeth. These services include:
  - Amalgam and resin-based composite fillings and fillings of similar materials
  - Recementation or repair of posts, crowns, veneers, inlays and onlays

Class II – Basic Services (continued)

- **Oral surgery services** – for simple extractions.

- **Non-surgical endodontic services** – treat teeth with diseased or damaged nerves. These services include:

  - Root canal treatments on permanent teeth and on primary teeth without permanent successors
  - Therapeutic pulpotomies or pulpal debridement
  - Vital pulpotomies on primary teeth

- **Non-surgical periodontic services** – treat diseases of the gums and the structures that support the teeth. These services include:

  - Periodontal maintenance following periodontal scaling and root planing or surgical periodontal treatment

- **Adjunctive general services** – are provided in connection with dental care. These services include:

  - General anesthesia or IV sedation in connection with oral surgery, when medically or dentally necessary as determined by BCBSM
  - Office visits for observation (during regularly scheduled hours)
  - Office visits after regularly scheduled hours
  - House and hospital calls
  - Antibiotic injections
  - Limited occlusal adjustments
  - Occlusal biteguards

- **Prosthodontic services** – repair or replace missing or deficient natural teeth or tissue. These services include:

  - Adjustments, repairs, relines, rebases and tissue conditioning for prosthodontic appliances
  - Recementation of fixed bridges

Class III – Major Services

- **Major restorative services** – repair decayed or damaged teeth. These services include:
  - Onlays, crowns and veneers, but only when a tooth cannot be restored with materials such as amalgam or resin-based composite fillings
  - Substructures, including cores with or without pins and posts with cores or pins
- **Other oral surgery services:**
  - Surgical and impacted tooth extractions and root removal
  - Surgical exposure and facilitation of eruption of unerupted teeth
  - Incision and drainage of cellulitis or fascial space abscesses of intraoral soft tissue
  - Alveoloplasty needed to prepare for a denture
  - Removal of exostoses (excess bony growths of the upper and lower jaw)
  - Excision of hyperplastic tissue per arch
  - Frenulectomies
- **Surgical endodontic services** – treat teeth with diseased or damaged nerves. These services include:
  - Apical surgeries on permanent teeth
  - Hemisection
- **Surgical periodontic services** – treat diseases of the gums and the structures that support the teeth. These services include:
  - Gingivectomies and gingivoplasties
  - Gingival flap procedures
  - Osseous surgeries
  - Soft tissue grafts
  - Periodontal scaling and root planing
  - Bone replacement grafts
  - Localized delivery of antimicrobial agents
- **Other prosthodontic services** – repair or replace missing or deficient natural teeth or tissue. These services include:
  - Complete dentures
  - Removable partial dentures and fixed partial dentures (bridges), including abutment crowns and pontics
  - Repairs of fixed partial dentures (bridges)
  - Stayplates to replace recently extracted permanent anterior (front) teeth

Section 4: Dental Services Not Covered

The services listed in this section are in addition to all other services **we do not cover**, which are stated elsewhere in this certificate.

Services that are listed in your certificate or riders as payable for members up to age 19 or pediatric members are payable only for members who are 18 or younger on the effective date of their coverage.

Services that are listed as payable for members age 19 and older or non-pediatric members are payable only for members who are age 19 or older on the effective date of their coverage.

Exclusions

The following services are **not** covered under this certificate unless you have a rider that adds coverage for them. You are responsible for paying the charges for these services:

- Services that are covered under medical or drug plans. These services include hospital, medical and prescription drug benefits. Any surgery that is usually covered under a medical plan is not covered under this certificate.
- Facility or hospital fees that a dentist, physician or hospital charges for treating a member in the hospital.
- Services to correct birth defects or developmental defects, such as cleft palate and jaw deformities.
- Services performed solely for cosmetic reasons (e.g., teeth bleaching, bonding or veneers when there is no decay or fracture).
- Personalized or customized services.
- Services and supplies that are not needed to diagnose or treat a dental condition or that were not recommended and approved by the attending dentist.
- Services to treat injuries to the mouth or jaw as a result of an accident.
- Charges for missed appointments.
- Charges for completing claim forms and other charts or reports.
- Charges for instruction in oral hygiene, diet or plaque control programs.
- Services provided by anyone other than a dentist; however, we will cover services of a dental hygienist when they work under the supervision of a dentist and the hygienist is licensed to perform the services.

Exclusions (continued)

- Office visits for observation for pediatric members.
- Office visits for observation for non-pediatric members during regularly scheduled hours when any other treatment is provided at that same visit.
- House and hospital calls for pediatric members.
- Drugs that are not parenterally administered by a dentist in connection with covered services.
- Antibiotic injections for pediatric members.
- Local anesthetic or analgesic billed as a separate service.
- Desensitizing medications.
- Supplies and barrier techniques used for infection control.
- Rubber dams.
- Consultations by dentists who are not treating the member unless the treating dentist requests the consultation and it relates to a covered treatment.
- Pulp tests performed at the same visit as:
  - An oral examination or evaluation
  - A restorative, endodontic, periodontic or prosthodontic service
- Space maintainers for missing front primary teeth or provided in connection with orthodontic treatment.
- Recementing a space maintainer, post, crown, veneer, inlay, onlay or bridge within six months of its initial placement.
- Replacing lost, missing, or stolen restorations, appliances or prosthetics of any type.
- Replacing or repairing space maintainers or orthodontic appliances.
- Duplicate X-rays used for administrative or other purposes.
- Diagnostic photographs, skull and facial bone survey films or imaging of any type.
- Sialography.
- Biopsies performed on the same date as any other service.
- Excisional or incisional biopsies of oral lesions.

Exclusions (continued)

- Bacteriology studies to determine oral health status or pathological agents.
- Histopathological examinations.
- Mounted case analyses.
- Emergency palliative treatment when any other treatment is provided on the same date (except for limited X-rays needed to diagnose the emergency condition).
- Charges for diagnostic tests that are paid as part of the total fee for:
  - An oral examination or evaluation, or
  - A restorative, endodontic, periodontal, surgical or prosthodontic service
- Charges for services related to restorations that are paid as part of the total fee for the restoration; these services include (but are not limited to):
  - Bases
  - Etchings
  - Liners
  - Temporary fillings
  - Local anesthesia
  - Preparative and other supplies
- Charges for services that are paid as part of the total fee for any other service.
- Restorations to stabilize teeth, change the occlusion, correct the vertical dimension, strengthen a tooth, prevent a future problem or close a space.
- Restorations to adjust or restore missing tooth structure due to abrasion, attrition or erosion, except with individual consideration by report.
- Occlusal biteguards for pediatric members.
- Full-mouth occlusal adjustments.
- Limited occlusal adjustments for pediatric members.
- Inlays, except under very limited circumstances with individual consideration by report.

Exclusions (continued)

- Prophylaxes or periodontal maintenance within 60 days of periodontal scaling and root planing or periodontal surgery.
- Prophylaxes in conjunction with scaling and root planing, except one quadrant with individual consideration by report.
- Localized delivery of antimicrobial agents for pediatric members.
- Repairs or adjustments of bridges, removable partial dentures or removable complete dentures within six months of their initial delivery; relines or rebases of removable partial or complete dentures within six months of their initial delivery.
- General anesthesia or IV sedation, unless medically or dentally necessary.
- Osseous surgery for pediatric members.
- Bone replacement grafts for pediatric members.
- Bone replacement grafts for non-pediatric members performed on a different date than osseous surgery or gingival flap procedures or done in conjunction with:
  - Restorative services
  - Endodontic services
  - Oral surgery services
  - Prosthodontic services
- Onlays, crowns and veneers on primary teeth, except with individual consideration by report when there is adequate root structure and no permanent successor.
- Sargenti root canal treatment.
- Temporary crowns for fracture of permanent teeth, except with individual consideration by report.
- Temporary fixed partial dentures on other than anterior permanent teeth.
- Temporary dentures.
- Coping as a definitive restoration, except with individual consideration by report.
- Periodontal surgical barriers and guided tissue regeneration.
- Periodontal splinting of any type.
- Precision attachments and cores or retainer bars for overdentures.

Exclusions (continued)

- Root canals for overdentures.
- Fitting a crown to a partial denture clasp.
- Dental implants and related services, including abutment placement and repair and maintenance of implants and surrounding tissues.
- Services for the diagnosis or treatment of temporomandibular joint dysfunction (TMJ).
- Orthodontia and related services.
- The more costly treatment when two or more methods are available to treat a condition. We will pay the approved amount, less the required coinsurance and deductible (if any), for the least costly acceptable treatment.
- Services or devices that are for personal use or for use at home, such as mouth trays and electric toothbrushes.
- Transportation or travel, even if recommended by a dentist.
- Any services, devices or charges not listed in this certificate as payable.

Limitations

The limitations on covered dental services are described below. They apply unless you have a rider that amends this certificate that says otherwise. We will pay for:

- Routine oral examinations and evaluations – twice every calendar year.
- A set (up to four) of bitewing X-rays – once every calendar year.
- Individual periapical films (up to six) – once every calendar year.
- A full-mouth series of X-rays (including bitewing and periapical X-rays taken on the same day) or panoramic X-rays – once every 60 months.
- Pulp tests – once every visit, regardless of the number of teeth evaluated.
- Diagnostic casts – once every 60 months per dentist.
- Routine prophylaxes (cleanings) – three times every calendar year for pediatric members and twice every calendar year for non-pediatric members.
- Fluoride treatments or topical fluoride varnishes – twice every calendar year for pediatric members.
  - For members at a moderate to high risk for tooth decay who are age three and younger, we pay for two additional topical fluoride varnishes every calendar year.
- Dental sealants – once per tooth every 36 months for first and second permanent molars for pediatric members. This period begins on the date of the member's first treatment.
- Space maintainers – once per quadrant every two years for missing posterior (back) primary teeth for members who are age 13 and younger.
- Oral brush biopsy sample collection – twice every calendar year.
- Replacement fillings for permanent teeth – once per tooth and surface every 48 months.
- Replacement fillings for primary teeth – once per tooth and surface every 24 months.

Limitations (continued)

- Recementing the following items – three times per tooth every calendar year:
  - Posts
  - Crowns
  - Veneers
  - Inlays
  - Onlays
  - Fixed partial dentures (bridges)
- Root canal treatment for a tooth involving one or more canals – once per tooth per lifetime. Retreatment of a root canal 12 or more months after the initial root canal treatment – once per tooth per lifetime.
- Periodontal maintenance – three times every calendar year for pediatric members and twice every calendar year for non-pediatric members in combination with routine cleanings.
- Periodontal scaling and root planing – once per quadrant every 24 months for pediatric members and once per quadrant every 36 months for non-pediatric members.
- Periodontal surgical services – once per quadrant every 36 months.
- Localized delivery of antimicrobial agents – one surface per tooth, three teeth per quadrant and a maximum of 12 teeth every calendar year for non-pediatric members only.
- Limited occlusal adjustments – up to five times every 60 months for non-pediatric members only.
- Occlusal biteguards, relines and repairs to occlusal biteguards – once every 60 months for non-pediatric members only.
- Relines or rebases of removable partial or complete dentures – once per arch every 36 months.
- Tissue conditioning – once per arch every 36 months.
- Onlays, crowns and veneers – once per permanent tooth every 84 months for members age 12 and older when a tooth cannot be restored with another filling material.
- Substructures – once per permanent tooth every 60 months for members age 12 and older.
- Complete dentures – once every 84 months.
- Bridges and removable partial dentures – once every 84 months for members age 16 and older.

Section 5: How Dental Benefits Are Paid

Choosing A Dentist

You may choose any dentist. However, your out-of-pocket cost is less when you select a Blue Dental PPO (in-network) dentist.

Our payment will vary based on whether your dentist is a:

- **PPO (In-Network) Dentist** – A dentist who has signed a PPO contract and agrees to accept our approved amount as full payment for covered services.
- **Non-PPO (Out-of-Network) Dentist** – A dentist who has not signed a PPO contract.
  - **Participating Dentist** – A non-PPO (out-of-network) dentist who participates with us through our Blue Par Select arrangement and agrees to accept our approved amount as full payment for covered services.
  - **Nonparticipating Dentist** – A non-PPO (out-of-network) dentist who does not participate with us on a per-claim basis and has not agreed to accept our approved amount as full payment for covered services. A nonparticipating dentist may bill you for the difference between what we paid you for covered services and the amount the dentist charges.

You should always ask whether your dentist is a Blue Dental PPO (in-network) dentist or if they agree to participate with us for every service provided.

If you choose to get services from a non-PPO (out-of-network) dentist who does not participate with us for these services, you will have to pay the difference (if there is any) between what we pay and what the dentist charges.

Please see the subsection titled, "*Paying for Services*" for more information about how we pay your dental claims.

Predetermination of Benefits

Your dentist may, but is not required to, submit their treatment plan to us for predetermination before providing you with certain complex or expensive services. We will review the plan before the services are performed and let you and your dentist know whether the planned services will be covered and how much we will pay for them.

If we determine that an alternative treatment will produce acceptable results at a lower cost, the most we will pay is our approved amount for the alternative treatment. If you and your dentist choose the treatment plan that was submitted by your dentist, you can apply the amount we approve for the recommended alternative to the original plan. However, you will be responsible for any difference in cost.

Predetermination is **not** a guarantee of payment. Our payment for predetermined services is based on the benefits that are available to you on the date the services are actually provided, and on the requirements, terms and conditions of this certificate.

An approved predetermination is valid for 24 months. If the services have not been completed within that time, you can ask for a new predetermination.

Filing Claims

You or your dentist must file a claim for benefits in the form we require within 24 months of the date services were completed before we will pay for covered services. The dentist must certify that services were provided as billed. We have the right to deny payment for services if we have not received a claim for those services within 24 months of the date they were completed.

For some procedures, we require documentation such as:

- X-rays
- Models of the teeth and jaw or
- A written explanation as to why the procedures were needed.

A BCBSM dental consultant reviews this documentation to determine dental necessity.

Paying For Services

We pay for covered dental services performed in the state of Michigan. Below is a description of how we pay for covered services.

- ***PPO (In-Network) Dentists:***
  Blue Dental PPO (in-network) dentists agree to accept our approved amount as payment in full for covered services. In most cases, our approved amounts for PPO (in-network) dentists are lower than our approved amounts for non-PPO (out-of-network) dentists, so the coinsurance amount you are responsible for will also be lower. We pay PPO (in-network) dentists directly. You are responsible for your deductible and/or coinsurance, as well as any charges for non-covered services.

- ***Non-PPO (Out-of-Network) Dentists:***
  Non-PPO (out-of-network) dentists may (but are not required to) participate with BCBSM on a per-claim basis through our Blue Par Select arrangement:

  – **Participating Dentist**
    - A non-PPO (out-of-network) dentist can participate on a per-claim basis by indicating on the claim form that we should pay them directly for covered services. By depositing our check, the dentist enters into a contract with us and agrees to accept our approved amount as payment in full for covered services.
    - You must pay your deductible and/or coinsurance, as well as any charges for non-covered services.
    - You should always ask whether your dentist is going to participate with us for every service they provide. If your dentist indicates that they will not participate with us for a particular service and you still choose to have them provide that service, you are responsible for any costs that exceed our reimbursement.

  - **Nonparticipating Dentist**
    - If a non-PPO (out-of-network) dentist chooses not to participate on a claim, we will pay you directly for covered services. Our payment will be the lesser of the amount billed or our approved amount, minus any required deductible and/or coinsurance and charges for non-covered services. You are responsible for the entire amount billed by your dentist, which may be higher than our approved amount.

Understanding Our Payment—Your Explanation of Benefits

After your claim is processed, we will send you an Explanation of Benefits (EOB) that provides the following information:

- The names of the dentist and the member
- A description of each service submitted on that claim
- The dates these services were provided
- The amounts the dentist charged for them and the amounts we allowed and paid for them
- What you saved by going to a participating dentist
- Any deductible and coinsurance you must pay
- What you may owe

If we denied payment for any of the services that were submitted, your EOB will explain why the services were denied.

Please call Dental Customer Service if you have questions regarding payments shown on your EOB.

Section 6: General Conditions of Your Contract

This section explains the conditions that apply to your certificate. They may make a difference in how, where and when benefits are available to you.

Assignment

Benefits covered under this certificate are for your use only. They cannot be transferred or assigned. Any attempt to assign them will automatically terminate all your rights under this certificate. You cannot assign your right to any payment from us, or for any claim or cause of action against us, to any person, provider, or other insurance company.

We will not pay a provider except under the terms of this certificate.

Changes in Your Address

You must notify us of any changes in your address. An enrollment/change of status form should be completed when you change your address.

Changes in Your Family

You must notify us of any changes in your family. Changes include marriage, divorce, birth, death, adoption, or the start or end of military service.

If you purchased this coverage **on** the Health Insurance Marketplace (Marketplace), you must notify the Marketplace within 60 days of the change. Once you provide this notice, the Marketplace will notify BCBSM of the date the change will take effect. The date of this change is set by federal law.

If you purchased this coverage **off** the Marketplace, we must receive notice from you within 60 days of when a dependent or spouse is removed from coverage, and within 60 days of when a dependent or spouse is added. Contract changes take effect as of the date of the event.

Changes to Your Certificate

BCBSM employees, agents or representatives cannot agree to change or add to the benefits described in this certificate.

- Any changes must be approved by BCBSM and the Michigan Department of Insurance and Financial Services.

- We may add, limit, delete or clarify benefits in a rider that amends this certificate. If you have riders, keep them with this certificate.

Coordination of Benefits

We coordinate the benefits payable under this certificate per Michigan's Coordination of Benefits Act.

Deductibles, Copayments and Coinsurances Paid Under Other Certificates

We do not pay any cost sharing that you must pay under any other certificate. An exception is when we must pay them under coordination of benefits requirements.

Dentist of Choice

You may continue to receive services from the dentist of your choice. However, if you receive services from a non-PPO (out-of-network) dentist, you may incur additional costs. (If you are covered under a Blue Dental EPO plan, you must choose a PPO (in-network) dentist.)

Enforceability of Various Provisions

Failure of BCBSM to enforce any of the provisions contained in this contract will not be considered a waiver of those provisions.

Entire Contract; Changes

This certificate, including your riders, if any, is the entire contract of your coverage. No change to this certificate is valid until approved by a BCBSM executive officer. No agent has authority to change this certificate or to waive any of its provisions.

Experimental or Investigational Services

We do not pay for a service, procedure, treatment, device or supply that has not been scientifically demonstrated to be safe and effective for treatment of the member's condition. BCBSM decides if something is experimental based on one or more of the following:

- Information from the American Dental Association and other appropriate professional organizations
- Information from the Food and Drug Administration and other government agencies
- Accepted national standards of practice in the dental profession
- Scientific data such as controlled studies in peer review journals or literature
- Information from the Blue Cross and Blue Shield Association or other local or national bodies

Fraud, Waste and Abuse

We do not pay for the following:

- Services that are not dentally necessary; may cause significant member harm; or are not appropriate for the member's documented dental condition.
- Services that are performed by a provider who is sanctioned at the time the service is performed.

Sanctioned providers have been sanctioned by BCBSM, the Office of the Inspector General, the Government Services Agency, the Centers for Medicare and Medicaid Services, or state licensing boards.

BCBSM will notify you if any provider you have received services from during the previous 12 months has been sanctioned. You will have 30 days from the date you are notified to submit claims for services you received prior to the provider being sanctioned. After that 30 days has passed, we will not process claims from that provider.

Genetic Testing

We will not:

- Adjust premiums for this coverage based on genetic information related to you, your spouse or your dependents
- Request or require genetic testing of anyone covered under this certificate
- Collect genetic information from anyone covered under this certificate at any time for underwriting purposes
- Limit coverage based on genetic information related to you, your spouse or your dependents

Grace Period

If you are not receiving a tax subsidy, a grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force. If you are receiving a tax subsidy, the grace period is three months.

Improper Use of Contract

If you let an ineligible person receive benefits (or try to receive benefits) under this certificate, we may:

- Refuse to pay benefits
- Terminate or cancel your coverage
- Begin legal action against you
- Refuse to cover your health care services at a later date

Notification

When we need to notify you, we mail it to you or your remitting agent. This fulfills our obligation to notify you.

Payment of Covered Services

The services covered under this certificate may be combined and paid according to BCBSM's payment policies.

Personal Costs

We will not pay for:

- Transportation and travel, even if recommended by a dentist, except as provided in this certificate
- Care, services, supplies or devices that are personal or convenience items
- Charges to complete claim forms
- Domestic help

Refund of Premiums

If we determine that we must refund a premium, we will refund up to a maximum of two years of payments.

Release of Information

You agree to let providers release information to us. This can include dental records and claims information related to services you may receive or have received.

We agree to keep this information confidential. Consistent with our Notice of Privacy Practices, this information will be used and disclosed only as authorized by law.

Reliance on Verbal Communications

If we tell you a member is eligible for coverage, or benefits are available, this does not guarantee that claims will be paid. Claims are paid only after:

- The reported diagnosis is reviewed
- Dental necessity is verified
- Benefits are available when the claim is processed

Right to Interpret Contract

During claims processing and internal grievances, BCBSM has the right to interpret and administer the terms of this certificate and any riders that amend it. BCBSM's final adverse decisions regarding claims processing and grievances may be appealed under applicable law.

Services Before Coverage Begins and After Coverage Ends

We will not pay for any services, treatment, care or supplies provided:

- Before the effective date of this certificate
- After the date on which coverage under this certificate ends

After coverage ends, we will pay for crowns, bridges, onlays, veneers or dentures, as described in this certificate, under the following conditions:

- They are ordered, or final impressions have been completed before your coverage ends.
- The procedure is completed, or the appliance is delivered within 60 days from the date the coverage ended.

Services That Are Not Payable

We do not pay for services that:

- You legally do not have to pay for or for which you would not have been charged if you did not have coverage under this certificate.
- Are available in a hospital maintained by the state or federal government, unless payment is required by law.
- Can be paid by government-sponsored health care programs, such as Medicare, for which you are eligible. We do not pay for these services even if you have not signed up to receive the benefits from these programs. However, we will pay for services if federal laws require the government-sponsored program to be secondary to this coverage.
- Are more costly than an alternate service or sequence of services that are at least as likely to produce equivalent results.
- Are not listed in this certificate as being payable.

Subrogation: When Others Are Responsible for Illness or Injury

If BCBSM paid claims for an illness or injury, and:

- Another person caused the illness or injury, or
- You are entitled to receive money for the illness or injury

Then BCBSM is entitled to recover the amount of benefits it paid on your behalf.

Subrogation is BCBSM's right of recovery. BCBSM is entitled to its right of recovery even if you are not "made whole" for all of your damages in the money you receive. BCBSM's right of recovery is not subject to reduction of attorney's fees, costs, or other state law doctrines such as common fund.

Whether you are represented by an attorney or not, this provision applies to:

- You
- Your covered dependents

You agree to:

- Cooperate and do what is reasonably necessary to assist BCBSM in the pursuit of its right of recovery
- Not take action that may prejudice BCBSM's right of recovery
- Permit BCBSM to initiate recovery on your behalf if you do not seek recovery for illness or injury
- Contact BCBSM promptly if you seek damages, file a lawsuit, file an insurance claim or demand, or initiate any other type of collection for your illness or injury

Subrogation: When Others Are Responsible for Illness or Injury (continued)

BCBSM may:

- Seek first priority lien on proceeds of your claim in order to fulfill BCBSM's right of recovery
- Request you to sign a reimbursement agreement
- Delay the processing of your claims until you provide a signed copy of the reimbursement agreement
- Offset future benefits to enforce BCBSM's right of recovery

BCBSM will:

- Pay the costs of any covered services you receive that are in excess of any recoveries made

Examples where BCBSM may utilize the subrogation rule are listed below.

- BCBSM can recover money it paid on your behalf if another person or insurance company is responsible:
  - When a third party injures you, for example, through medical malpractice;
  - When you are injured on premises owned by a third party; or
  - When you are injured and benefits are available to you or your dependent, under any law or under any type of insurance, including, but not limited to medical reimbursement coverage.

Subscriber Liability

At the discretion of your provider, certain technical enhancements may be employed to complement a dental procedure. These enhancements may involve additional costs above and beyond the approved maximum payment level for the basic procedure. The costs of these enhancements are not covered by this certificate. Your provider must inform you of these costs. You then have the option of choosing any enhancements and assuming the liability for these additional charges.

Termination of Coverage

You must notify us if you want to terminate your coverage under this certificate. Once you provide us with this notice, your coverage will end on one of the following dates:

If you purchased this coverage **on** the Marketplace, you may terminate it only if you provide the Marketplace with proper notice.

- If you notify us at least 14 days before the date you want your coverage to end, your coverage will end on your requested date, or
- If you notify us in less than 14 days before the date you want your coverage to end, we will end it on your requested date only if it is feasible for us to do so, or
- In all other cases, we will end your coverage 14 days after you request that your coverage be terminated.

If we decide to terminate your coverage under this certificate, we may notify you of our decision at least 30 days before your last day of coverage. The notification will include the reason for the termination and the date your coverage will end.

Time Limit for Filing Claims

We will not pay for claims for services that are not filed within two years from the date of service.

Time Limit for Legal Action

You may not begin legal action against us later than three years after the date of service of your claim. If you are bringing legal action about more than one claim, this time limit runs independently for each claim.

You must first exhaust the grievance and appeals procedures, as explained in this certificate, before you begin legal action. You cannot begin legal action or file a lawsuit until 60 days after you notify us that our decision under the grievance and appeals procedure is unacceptable.

Unlicensed and Unauthorized Providers

We do not pay for services provided by persons who are not:

- Appropriately credentialed or privileged (as determined by BCBSM) or
- Legally authorized or licensed to order or provide such services.

What Laws Apply

This certificate will be interpreted under the laws of the state of Michigan and federal law where applicable.

Workers' Compensation

We do not pay for treatment of work-related injuries covered by workers' compensation laws. We do not pay for work-related services you get at an employer's medical clinic or other facility.

Section 7: Definitions

This section explains the terms used in your certificate. The terms are listed in alphabetical order.

Abutment
A connection to an implant that offers retention, support and stabilization of a false replacement tooth.

Accidental Injury
An external force to the lower half of the face or jaw that damages or breaks sound natural teeth, periodontal structures (gums) or bone.

Adverse Benefit Decision
A decision to deny, reduce or refuse to pay all or part of a benefit. It also includes a decision to terminate or cancel coverage.

Amount Billed
The dollar amount that the dentist reports to BCBSM on a dental claim, less any amount that the dentist may discount, waive, rebate or has not, in good faith, attempted to collect.

Approved Amount
The lower of the amount billed or the BCBSM maximum payment level for a covered service. Coinsurances or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment. The approved amount for covered services provided by PPO (in-network) dentists may be different from the approved amount for covered services provided by non-PPO (out-of-network) dentists.

BCBSM
Blue Cross Blue Shield of Michigan or another entity or person Blue Cross Blue Shield of Michigan authorizes to act on its behalf.

By Report
A written explanation from the dentist that justifies the need for a procedure.

Calendar Year
A period of time beginning January 1 and ending December 31 of the same year.

Cancellation
An action that ends a member's coverage dating back to the effective date of the member's contract. This results in the member's contract never having been in effect.

Certificate
This book, which describes your benefit plan, and any riders that amend it.

Claim for Damages
A lawsuit against, or demand to, another person or organization for compensation for an injury to a person.

Coinsurance
A portion of the approved amount that you must pay for a covered service. This amount is determined based on the approved amount at the time the claims are processed. Your coinsurance is not altered by an audit, adjustment or recovery.

Contract
This certificate and any related riders, your signed application for coverage and your BCBSM ID card.

Copayment
The dollar amount that you must pay for a covered service. Your copayment is not altered by any audit, adjustment or recovery.

Cost Sharing
Copayments, coinsurances, and deductibles you must pay under this certificate.

Course of Treatment
A planned program of services for the treatment of a dental condition diagnosed by a dentist as the result of an oral examination/evaluation. A course of treatment begins on the date a dentist first provides a service to treat the dental condition.

Covered Services
A service that is identified as payable in this certificate. Such services must be dentally necessary, as defined in this certificate, and ordered or performed by a provider that is legally authorized or licensed to order or perform the service. The provider must also be appropriately credentialed or privileged, as determined by BCBSM, to order or perform the service.

Deductible
The amount that you must pay for covered services, under any certificate or rider, before benefits are payable. Payments made toward your deductible are based on the approved amount at the time the claims are processed. Your deductible is not altered by an audit, adjustment, or recovery.

Dentally Appropriate
Services that are consistent with how providers generally treat their patients. The services can be those used to diagnose or for treatment. They are based on standard practices of care and are supported by evidence of their effectiveness.

Dentally Necessary
A service or device must be dentally necessary and appropriate according to generally accepted standards and patterns of dental practice for it to be covered by BCBSM. Dentists acting for BCBSM decide dental necessity. It is based on criteria and guidelines developed by these dentists who are acting for their respective peer provider type or specialty.

- The covered service is accepted as necessary and appropriate for the member's condition. It is not mainly for the convenience of the member or dentist.
- Covered services are subject to certain restrictions based on:
  - Policies consistent with generally accepted standards of dental practice
  - Those specific contracts that only pay for the least expensive acceptable treatment
- In the case of diagnostic testing, the results are essential to and are used in diagnosis or management of the member's condition.

When there are no established criteria, dental need will be decided by the accepted standards and practices by the dentists who are providing services for BCBSM members.

Dental Services
Services for diagnosis, prevention or treatment in connection with the care, restoration, filling, removal or replacement of teeth or the structures directly supporting the teeth.

Dentist
- **PPO (In-Network) Dentist**
  A dentist who has signed a contract to participate in the Preferred Provider Organization (PPO) network used by BCBSM. PPO (in-network) dentists agree to accept our approved amount as full payment for covered services.
- **Non-PPO (Out-of-Network) Dentist**
  A dentist who has not signed a contract to participate in the Preferred Provider Organization (PPO) network used by BCBSM. Non-PPO (out-of-network) dentists may (but are not required to) participate with BCBSM on a per-claim basis through our Blue Par Select arrangement.
  - **Participating Dentist**
    A non-PPO (out-of-network) dentist who participates on a Blue Dental claim and receives payment directly from BCBSM. Participating dentists agree to accept our approved amount as full payment for covered services.
  - **Nonparticipating Dentist**
    A non-PPO (out-of-network) dentist who does not participate on a Blue Dental claim and receive payment directly from BCBSM. Nonparticipating dentists do not agree to accept our approved amount as full payment for covered services.

Department of Insurance and Financial Services (DIFS)
The department that regulates insurers in the state of Michigan.

Effective Date
The date your coverage begins under this contract. This date is established by BCBSM.

Exclusions
Situations, conditions, services or devices that are not covered by the subscriber's contract.

Experimental or Investigational Treatment
Treatment that has not been scientifically proven to be as safe and effective for treatment of the member's conditions as conventional treatment. Sometimes it is referred to as "investigational" or "experimental services." BCBSM is responsible for deciding if the use of any service is experimental or investigational.

First Priority Security Interest
The right to be paid before any other person from any money or other valuable consideration recovered by:

- Judgment or settlement of a legal action
- Settlement not due to legal action
- Undisputed payment

This right may be invoked without regard for:

- Whether plaintiff's recovery is partial or complete
- Who holds the recovery
- Where the recovery is held

Hygienist
A person who is licensed to perform specific dental procedures under the supervision of a licensed dentist. The procedures include, but are not limited to:

- Scaling
- Root planing
- Prophylaxis (teeth cleaning)
- Fluoride

Lien
A first priority security interest in any money or other thing of value obtained by judgment, settlement or otherwise up to the amount of benefits, costs and legal fees BCBSM paid because of the plaintiff's injuries.

Member
Any person eligible for dental care services under this certificate on the date the services are provided. This means the subscriber and any eligible dependents listed on the application. The member is the "patient" when receiving covered services.

Nonparticipating Dentist
See the definition of "Dentist".

Non-Pediatric Member
Members who are age 19 or older when their coverage begins are considered non-pediatric members.

Non-PPO (Out-of-Network) Dentist
See the definition of “Dentist”.

Ordered
When the dentist has completed preparing the mouth for an inlay, onlay, crown, bridge or denture and has taken final impressions for the laboratory.

Participating Dentist
See the definition of “Dentist”.

Patient
The subscriber or eligible dependent who is awaiting or receiving dental care and treatment.

Pediatric Member
Members who are age 18 or younger when their coverage begins are considered pediatric members until the end of the calendar year in which they turn age 19.

Plaintiff
The person who brings the lawsuit or claim for damages. The plaintiff may be the injured party or a representative of the injured party.

Post-Service Grievance
A post-service grievance is an appeal that you file when you disagree with our payment decision or our denial for a service that you have already received.

PPO (In-Network) Dentist
See the definition of “Dentist”.

Predetermination
A process by which a dentist submits a treatment plan to us before treatment begins. We return a copy of the proposed treatment plan to the dentist indicating covered services under the terms of your contract or available alternative treatments as determined by BCBSM.

Pre-Service Grievance
A pre-service grievance is an appeal that you can file when you disagree with our decision not to pre-approve a service you have not yet received.

Provider
A dentist or hygienist who provides services or supplies related to dental care.

Quadrant
Dental arches are divided into equal sections known as quadrants. A quadrant begins at the mid-line (center teeth) of the arch and extends back to the end of the upper or lower jaw.

Qualifying Event
One of the following events that allows you to enroll in different health care coverage or change your current coverage:

- Start or end of military service. Members must perform military duty for more than 30 days.
- Death of the subscriber
- Divorce
- Loss of dependent status due to age, marriage, changes in student status, etc.
- The member becomes entitled to coverage under Medicare

The examples in this definition are not exhaustive and may change. Please call Customer Service for more information about qualifying events.

Reimbursement
The amount BCBSM pays for a covered procedure. BCBSM's reimbursement is based on the lesser of the amount billed or the BCBSM maximum payment level for that procedure on the date the service is provided minus any cost sharing you are required to pay.

Remitting Agent
Any individual or organization that has agreed, on behalf of the subscriber, to:

- Collect or deduct from wages or other sums owed to the subscriber
- Pay the subscriber's BCBSM bill

Rescission
The cancellation of coverage that dates back to the effective date of the member's contract and voids coverage during this time.

Rider
A document that amends this certificate by adding, limiting, deleting or clarifying benefits.

Right of Recovery
The right of BCBSM to make a claim against you, your dependents or representatives if you or they have received funds from another party responsible for benefits paid by BCBSM.

Services
Care, procedures and supplies given by a dental care provider to diagnose or treat dental conditions.

Spouse
An individual who is legally married to the subscriber.

Subrogation
Subrogation occurs when BCBSM assumes the right to make a claim against or to receive money or other thing of value from another person, insurance company or organization. This right can be your right or the right of your dependents or representatives.

Subscriber
The person who signed and submitted the application for coverage and meets the group's eligibility requirements.

Supervision
When a dentist oversees the care of a member, is available when necessary, but is not at chair side while service and treatment are rendered.

Termination
An action that ends a member's coverage after the member's contract takes effect. This results in the member's contract being in effect up until the date it is terminated.

We, Us, Our
Used when referring to Blue Cross Blue Shield of Michigan or another entity or person Blue Cross Blue Shield of Michigan authorizes to act on its behalf.

You and Your
Used when referring to any person covered by the subscriber's contract.

Section 8: Additional Information You Need to Know

We want you to be satisfied with our how we administer your coverage. If you have a question or concern about how we processed your claim or request for benefits, we encourage you to contact Dental Customer Service. The telephone number is on the back of your Blues ID card and in the top right-hand corner of your Explanation of Benefits (EOB) statements.

Grievance and Appeals Process

We have a formal grievance and appeals process that allows you to dispute an adverse benefit decision or rescission of your coverage.

An adverse benefit decision includes a:

- Denial of a request for benefits
- Reduction in benefits
- Failure to pay for an entire service or part of a service
- Rescission of coverage
  - A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, such as a cancellation that treats a policy as void from the time of enrollment.

You may file a grievance or appeal about any adverse benefit decision or rescission within 180 days after you receive the claim denial. The dollar amount involved does not matter.

If you file a grievance or appeal:

- You will not have to pay any filing charges.
- You may submit materials or testimony at any step of the process to help us in our review.
- You may authorize another person, including your physician or dentist, to act on your behalf at any stage in the standard review process. Your authorization must be in writing. Please call the Dental Customer Service number on the back of your Blues ID card and ask for a *Designation of Authorized Representative and Release of Information* form. Complete it and send it with your appeal.
- Although we have 60 days to give you our final determination for post-service appeals, you have the right to allow us additional time if you wish.
- You do not have to pay for copies of information relating to our decision to deny or reduce benefits or rescind your coverage.

Grievance and Appeals Process (continued)

The grievance and appeals process begins with an internal review by DentaQuest. Once you have exhausted your internal options, you have the right to a review by the Michigan Department of Insurance and Financial Services (DIFS).

You do not have to exhaust our internal grievance process before requesting an external review in certain circumstances:

- We waive the requirement
- We fail to comply with our internal grievance process
  - Our failure to comply must be for more than minor violations of the internal grievance process.
    - Minor violations are those that do not cause and are not likely to cause you prejudice or harm.

Standard Internal Review Process

Step 1: You or your authorized representative must send DentaQuest a written statement explaining why you disagree with our decision.

Mail your written grievance to:

DentaQuest
Attn: Complaints & Grievances
P.O. Box 2906
Milwaukee, WI 53201-2906

Step 2: DentaQuest will contact you to schedule a conference once they receive your grievance. During your conference, you can provide them with any other information you want them to consider in reviewing your grievance. The written decision they give you after the conference is our final decision.

Step 3: If you disagree with our final decision, or you do not receive our decision within 60 days after DentaQuest received your original grievance, you may request an external review. See below for how to request a standard external review.

Grievance and Appeals Process (continued)

Standard External Review Process

Once you have gone through our standard internal review process, you or your authorized representative may request an external review.

The standard external review process is as follows:

Within 127 days of the date you receive or should have received our final decision, send a written request for an external review to the Department listed below. You may mail your request and the required forms provided by DentaQuest to:

Department of Insurance and Financial Services
Office of General Counsel
Health Care Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

You may also contact the Department with your request by phone, fax, or online:

Phone: 1-877-999-6442
Fax: 517-284-8837
Online: https://difs.state.mi.us/Complaints/ExternalReview.aspx

When you file a request for an external review, you will have to authorize the release of medical/dental records that may be required to reach a decision during the external review.

If you ask for an external review about an issue requiring the expertise of a dental practitioner and the issue is found to be appropriate for external review, the Department will assign an independent review group to conduct the external review. The group will consist of independent clinical peer reviewers. The recommendation of the independent review group will only be binding on you and BCBSM if the Department decides to accept the group's recommendation. The Department will make sure that this independent review group does not have a conflict of interest with you, with us, or with any other relevant party.

Reviews of Dental Issues

Step 1: The Department will assign an independent review group to review your request if it concerns a dental issue that is appropriate for an external review.

- You can give the Department additional information within seven days of asking for an external review. BCBSM and DentaQuest will provide the independent review group all the information used for the final decision within seven days of getting the notice of your request from the Department.

Step 2: The review group will recommend within 14 days whether the Department should uphold or reverse our decision. The Department must decide within seven business days if they are going to accept the recommendation and then they must notify you of their decision. The decision is your final administrative remedy under the Patient's Right to Independent Review Act of 2000.

Grievance and Appeals Process (continued)

Reviews of Nondental Issues

Step 1: The Department's staff will review your request if it involves issues that do not require the expertise of a dental practitioner and is appropriate for an external review.

Step 2: They will recommend if the Department should uphold or reverse our decision. The Department will notify you of the decision. This is your final administrative remedy under the Patient's Right to Independent Review Act of 2000.

Expedited Internal Review Process

- You may file a request for an expedited internal review if your physician or dentist shows (verbally or in writing) that following the timeframes of the standard internal process will seriously jeopardize:
  - Your life or health, or
  - Your ability to regain maximum function

You may request an expedited internal review if you believe:

- We wrongly denied, terminated, cancelled or reduced your coverage for a service before you received it, or
- We failed to respond in a timely manner to a request for benefits or payment

The process to submit an expedited internal review is as follows:

Step 1: Call 1-888-826-8152 to ask for an expedited review. Your physician or dentist may also call this number to confirm that you qualify for an expedited internal review.

Step 2: DentaQuest must provide you with our decision within 72 hours of receiving both your grievance and the physician's/dentist's substantiation.

Step 3: If you do not agree with our decision, you may, within 10 days of receiving it, request an expedited external review from the Michigan Department of Insurance and Financial Services.

Grievance and Appeals Process (continued)

Expedited External Review Process

If you have filed a request for an expedited internal review, you or your authorized representative may ask for an expedited external review from the Department of Insurance and Financial Services.

You may request an expedited external review if you believe:

- We wrongly denied, terminated, cancelled or reduced your coverage for a service before you receive it, or
- We failed to respond in a timely manner to a request for benefits or payment.

The expedited external review process is as follows:

Step 1: A request for external review form will be sent to you or your representative with our final adverse determination.

Step 2: Complete this form and mail it to:

Department of Insurance and Financial Services
Office of General Counsel
Health Care Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

You may also contact the Department with your request by phone, fax, or online:

Phone: 1-877-999-6442
Fax: 517-284-8837
Online: https://difs.state.mi.us/Complaints/ExternalReview.aspx

When you file a request for an external review, you will have to authorize the release of medical or dental records that may be required to reach a decision during the external review.

Step 3: The Department will decide if your request qualifies for an expedited external review. If it does, the Department will assign an independent review group to conduct the review. The group will recommend within 36 hours if the Department should uphold or reverse our decision.

Step 4: The Department must decide whether to accept the recommendation within 24 hours. You will be notified of the Department's decision. This decision is the final administrative remedy under the Patient's Right to Independent Review Act of 2000.

Pre-Service Appeals

For members who must get approval <u>before</u> obtaining certain health services.

Your plan may require predetermination of certain services. If predetermination is denied, you can appeal the decision.

Please follow the steps below to request a review. If you have questions or need help with the appeal process, please call the Dental Customer Service number on the back of your Blues ID card.

All appeals must be requested in writing. DentaQuest must receive your written request within 180 days of the date you received notice that the service was not approved.

Requesting a Standard Pre-Service Review

You may make the request yourself, or your dentist or someone else acting on your behalf may make the request for you. If another person will represent you, that person must obtain written authorization to do so. Please call the Dental Customer Service number on the back of your Blues ID card and ask for a *Designation of Authorized Representative and Release of Information* form. Complete it and send it with your appeal.

<u>Your request for a review must include</u>:

- Your enrollee ID and group numbers, found on your Blues ID card;
- A daytime phone number for both you and your representative;
- The member's name if different from yours; and
- A statement explaining why you disagree with our decision and any additional supporting information.

Once DentaQuest receives your appeal, they will provide you with our final decision within 30 days.

Requesting an Urgent Pre-Service Review

If your situation meets the definition of urgent under the law, your request will be reviewed as soon as possible, generally within 72 hours. An urgent situation is one in which, in the opinion of your physician or dentist, your health may be in serious jeopardy or you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an urgent review or a simultaneous expedited external review.

See above for the steps to follow to request an expedited external review.

For more information on how to ask for an urgent review or simultaneous expedited external review, call the Dental Customer Service number listed on the back of your Blues ID card.

Need More Information?

At your request and without charge, DentaQuest will send you details from your dental care plan if the decision was based on your benefits. If the decision was based on medical guidelines, DentaQuest will provide you with the appropriate protocols and treatment criteria. If a medical or dental expert was involved in making the decision, the expert's credentials will be provided.

To request information about your plan or the medical/dental guidelines used, or if you need help with the appeal process, call the Dental Customer Service number on the back of your Blues ID card.

Other Resources to Help You

You can contact the Director of the Michigan Department of Insurance and Financial Services for assistance.

To contact the Director:

- Call toll-free at 1-877-999-6442; or
- Fax to 517-284-8837; or
- Go online at https://difs.state.mi.us/Complaints/ExternalReview.aspx; or
- Mail to: Department of Insurance and Financial Services
  P.O. Box 30220
  Lansing, MI 48909-7720

We Speak Your Language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

ھەبێ ، ئەگەر تۆ یان کەسێک کە یارمەتی دەدەیت پێویستی بە یارمەتی ھەیە، مافی ئەوەت ھەیە بە بێ تێچوو یارمەتی و زانیاری بە زمانەکەی خۆت وەربگریت. بۆ قسەکردن لەگەڵ وەرگێڕ، پەیوەندی بە ژمارەی خزمەتگوزاری بەکارھێنەران لەسەر پشتەوەی کارتەکەت بکە، یان 877-469-2583 TTY:711 پەیوەندی بکە ئەگەر ئەندام نیت.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号　(メンバーでない方は 877-469-2583, TTY: 711) までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important Disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 1-877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 1-888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 1-800-368-1019, TTD: 1-800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Section 9: How to Reach Us

This section lists ways for you to get information quickly.

Call Us

If you have questions about claims or coverage, you can call Dental Customer Service at **1-888-826-8152** Monday through Friday from 8 a.m. to 7 p.m. Eastern Time.

Please have your Blues ID card with your group and enrollee ID numbers ready when you call us.

Write Us

If you have complaints or concerns, you can write to us:

DentaQuest
Attn: Complaints & Grievances
P.O. Box 2906
Milwaukee, WI 53201-2906

Check Our Websites

If you want general information about us or your dental plan, you can visit http://www.bcbsm.com/ 24/7. You can sign in to:

- Access information about your Blue Dental coverage
- Review your Explanation of Benefits
- Review your claims

Visit http://www.mibluedentist.com/ to locate a PPO (in-network) or Blue Par Select participating dentist near you.

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