Delta Dental of Rhode Island

Certificate Of Coverage

Delta Dental PPO Plus Premier
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Welcome to Delta Dental of Rhode Island’s national program. This Certificate is a contract between you and Delta Dental of Rhode Island. You complete a benefits application and agree to pay applicable fees. We agree to provide benefits.

Your plan sponsor has selected a Plan for you and your covered dependents. This Certificate, along with the Benefits Summary, describes the Plan. It describes the dental services covered by your Plan. It also explains how each is paid for and tells you how to use the Plan. Please contact Customer Service if you have any questions.

Our toll free Customer Service number is:

1-800-843-3582

You may call Customer Service Monday through Thursday 8 a.m. to 7 p.m., ET and Fridays from 8 a.m. to 5 p.m., ET. You may call our automated information line 24 hours a day, seven days a week.

You may also visit us online at www.deltadentalri.com.

Send claims and written correspondence to:

Delta Dental of Rhode Island
P.O. Box 1517
Providence, RI 02901-1517

This dental plan does not cover the pediatric dental services covered by the essential health benefits (EHB) benchmark plan in Rhode Island.
Definitions
This document contains words used in insurance and dentistry. These words have specific meanings that are described below. Insurance or dental terms used in this document will be in italics. If you are not clear about the meaning of the words used, please refer back to this page.

- **Adverse Benefit Decision** means a decision by Delta Dental not to pay (in whole or in part) for a covered service, including a denial; reduction; termination; or, failure to make a payment based on the imposition of a pre-existing condition exclusion; a source of injury exclusion; retroactive rescission of coverage; or, other limitation on covered services.

- **Allowance** means the amount we base payment on for a covered service or procedure. The Allowance for a Participating Dentist is the LOWEST of the:
  a) Amount set by the local Delta Dental Plan for each specific dentist;
  b) Maximum amount the local Delta Dental Plan will pay any dentist for a covered service or procedure; or
  c) Amount the dentist actually charges.

  Participating dentists cannot charge Delta Dental patients more than the allowance for a participating dentist.

  The Allowance for a Non-participating Dentist is:
  a) The lesser of the dentist’s charge or the amount determined by the local Delta Dental Plan; or
  b) The lesser of the dentist’s charge or an amount equal to a percent of the Delta Submitted Charges Database for that procedure; or
  c) The lesser of the dentist’s charge or an amount listed on the local Delta Dental Plan’s non-participating dentist fee table for that procedure.

- **Annual Maximum** means the most we will pay for covered services for a continuous 12-month period (usually a calendar year). The annual maximum is stated in the Benefits Summary.

- **Benefits Summary** is a summary description of the services covered under this dental policy; with a schedule that shows you how much we pay toward a procedure. If a service is not listed in the Benefits Summary, we will not pay for it.

- **Certificate** means this document and the Benefits Summary. This Certificate is your policy.

- **Coinsurance/Copayment** means the amount you pay for covered services, after the deductible, if any, is met. Coinsurance is usually shown as a percentage and copayment as a fixed dollar amount. The amount of coinsurance/copayment varies with the type of covered services and is shown in the Benefits Summary.

- **Covered Services** means those services and procedures listed in the Benefits Summary. All covered services must be dentally necessary and appropriate to qualify for payment.

- **Date of Service** means the date that the service was done. For services requiring more than one visit, except orthodontics, the Date of Service is the final completion date (Examples: the insertion date of a denture; the date a permanent crown is cemented).
- **Deductible** means the amount you pay toward **covered services** before we begin paying benefits. **Deductibles** must be met each **policy year**. **Deductibles** may vary by type of benefits; or, by type of provider (participating vs. non-participating). They are specific dollar amounts for each **subscriber** and/or **dependent** per **policy year** or per lifetime as specified.

- **Dentally Necessary** (Dental Necessity) means that the dental services provided are appropriate, in terms of type, amount, frequency, level, setting, and duration to the **member’s** diagnosis or condition. All **covered services** must be **dentally necessary** and appropriate to qualify for payment. We will make a determination whether a service is dentally necessary based on this “dentally necessary” standard using criteria which is set forth in the utilization review plan and guidelines (“review guidelines”) that we are required to file with the Rhode Island Department of Health in order to be able to carry out utilization review activities. These guidelines are based on generally accepted dental or scientific evidence and are consistent with generally accepted practice parameters. If a service is denied based on dental necessity, we will send you and your dentist a written notice explaining the reason(s) for the denial. The notice will refer to a guideline; protocol; or, criteria we used to make the denial. Refer to the **Claims Procedures** section of this **Certificate** for details on how to get more information regarding the review decision and procedures for filing an appeal. A copy of our review guidelines is available on our website at: www.deltadentalri.com.

- **Dentist** means any person duly licensed as a Doctor of Dental Medicine (DMD) or Doctor of Dental Surgery (DDS) practicing within the authority of his or her license. The term dentist includes an oral surgeon.

- **Dependent** typically means your **spouse** and your unmarried **dependent** children up to a certain age. A **spouse** includes a party to a same sex marriage; civil union; or, similar union entered into under applicable state laws. Refer to your Benefits Summary for dependent children age limits. **Your plan sponsor determines dependent eligibility terms.** If you have family coverage, your **newborn infant** and a **newborn infant of a dependent child** are eligible for coverage from birth. **Adopted children** are covered from the date of placement in the home. Foster children are covered from the date of the filing of the petition to adopt. Stepchildren and children under your own or your spouse's legal guardianship who permanently live in your household and are chiefly dependent on you for support, are also considered dependent children. Married children are not considered dependents, regardless of their age.

- **Effective Date** means the date as shown on our records on which your **coverage** begins.

- **Emergency Service** means a service given to treat a person with a serious medical or health problem. That person needs to be seen by a provider **right away** to prevent permanent damage or death. A medical problem includes physical, mental, and dental conditions. (Emergency service is limited to services which are palliative and/or temporary and does not include services such as permanent fillings, crowns or root canals.)

- **Endodontics** means a specialty of dentistry that deals with treatment of diseases of the dental pulp (nerves, blood vessels and other tissues within the tooth). A root canal is an example of endodontic treatment.

- **Hygienist** means any person duly licensed as a dental **hygienist** practicing within the authority of his or her license.
• **Lifetime Maximum** means the most we will pay for *covered services* during a *subscriber's* or *dependent's* lifetime. This provision usually applies only to orthodontic services and implants if covered by your plan.

• **Local Delta Dental Plan** means the Delta Dental Plan that contracts with the *participating dentist* in a particular state. There are Delta Dental Plans covering all 50 states.

• **Member** means a *Subscriber* or *Dependent*.

• **Non-participating Dentist** means a *dentist* who does not have a contract with Delta Dental.

• **Orthodontics** means a specialty of dentistry concerned with prevention and correction of abnormalities in tooth position and their relationship to the jaw (straightening of teeth).

• **Participating Dentist** means a *dentist* who has a contract with the *local Delta Dental Plan* to provide *covered services* to *subscribers* and *dependents*. A *participating dentist* may belong to the PPO network, the Premier network, or both.

• **Pedodontics** means a specialty of dentistry concerned with the treatment of children.

• **Periodontics** means a specialty of dentistry concerned with diseases of the gums and other supportive structures of the teeth.

• **Plan** means the terms, conditions and benefits described in this *Certificate* and the Benefits Summary.

• **Plan Sponsor** means your employer or other organization / association that is sponsoring the *Plan*. In the case of a group subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended, the *Plan Sponsor* is the individual or entity designated under that Act.

• **Policy Year** means the continuous 12 month period under which coverage is offered by your *plan sponsor*. Your policy year is either the calendar year or the timeframe beginning with your group’s coverage start date and ending 12 months later. *Your annual maximum* is the most we will pay for *covered services* during each policy year.

• **Prosthodontics** means a specialty of dentistry concerned with the replacement of missing teeth by bridges and dentures.

• **Spouse** means your *legal spouse*. A *spouse* includes a party to a same sex marriage; civil union; or, similar union entered into under applicable state laws.

• **Subscriber** means someone who has applied for coverage and been approved by us and is eligible to receive benefits under this *Certificate*.

• **Waiting Period** is the amount of time you must wait from your *effective date* before a service is covered. If your plan has a waiting period, it will be shown in the Benefits Summary that goes with this *Certificate*.

• **We, Our, Us and Delta Dental** means Delta Dental of Rhode Island located at 10 Charles Street, Providence, RI 02904-2208.

• **You and yours** means the *Subscriber*. 

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When You Join the Plan

Who Can Join
You and/or your eligible dependents can join the Plan if your Plan Sponsor agrees and complies with our underwriting guidelines. Your plan sponsor determines eligibility requirements for dependents.

The Plan does not limit coverage based on genetic information. We will not: (i) adjust premiums based on genetic information; (ii) request / require genetic testing; or, (iii) collect genetic information from an individual prior to, or in connection with, enrollment in a plan; or, at any time for underwriting purposes.

Your eligible dependents typically are:

- **Your legal spouse.** A spouse includes a party to a same sex marriage; civil union; or, similar union entered into under applicable state laws. In the event of divorce, your ex-spouse will remain eligible for continued coverage under the policy without additional premium until either spouse remarries. This is true unless the divorce or separation judgment states otherwise. If you remarry, the ex-spouse may, if so stated in the divorce judgment, stay covered as a member at additional premium. 

- **Your unmarried dependent children** up to a certain age. Refer to your Benefits Summary for age limits.

- **Your unmarried children who have reached the dependent age limit up to a higher student age limit,** if a student at an accredited secondary school or college and primarily dependent on you for support.

  NOTE: Your plan sponsor must agree to purchase coverage for students. If applicable, the student age limit will be listed in your Benefits Summary. Your plan sponsor determines student eligibility terms.

- **Your unmarried children who have reached the dependent age limit; and, who are mentally or physically disabled and cannot earn a living.** To continue coverage, you must submit proof of your child's disability within 30 days of the child reaching the dependent age limit. The proof must be satisfactory to us. You must continue to provide proof of the disability upon request.

How You Join
You enroll by completing, signing and returning to us or your plan sponsor an applicable form. Forms are available from us or your plan sponsor, or you may be able to enroll online. If your family status changes and you need to add or remove dependents from your plan, contact us or your plan sponsor. We can only accept membership changes from a subscriber or your plan sponsor.

When Coverage Begins
Coverage generally starts the first of the month after we accept your completed and signed enrollment form and payment arrangements.

Your plan sponsor can tell you if a waiting period is required before you can join the Plan.
You must wait until your plan sponsor’s next open enrollment period, if you or your dependent(s) do not enroll when first eligible. You may also enroll when there is a qualifying event. We establish what a qualifying event is. Examples include loss of other coverage, marriage, or death.

If you marry, you may enroll your spouse within 60 days of marriage. You must wait until your plan sponsor’s next open enrollment period if your spouse does not enroll when first eligible. Your spouse may also enroll when there is a qualifying event.

If you have family coverage, your newborn infant and the newborn infant of a dependent child are covered from birth. Adopted children are covered from the date of home placement. Foster children are covered from the date of the petition to adopt filing. Stepchildren and children are considered dependent children if they: are under your own or your spouse's legal custody; permanently live in your household; and, chiefly depend on you for support. We do not consider married children dependents, regardless of their age.

Coverage generally begins on the first of the month after we accept your enrollment form. If you don’t enroll within 60 days, you must wait until the next open enrollment period to enroll dependents. Dependents may enroll when there is a qualifying event.

Please notify us and your plan sponsor of any changes in your or your dependent's status. This includes marriage; births; attainment of the dependent or student (if applicable) age limits; or, changes in your address. This will help maintain up to date eligibility and billing records.

The Cost of Your Coverage
You and/or your plan sponsor pay the cost of coverage for you and your eligible dependents. The cost of coverage is based on the arrangement agreed to by your plan sponsor. This arrangement must comply with our underwriting guidelines.

When Coverage Ends
Your plan sponsor or we may cancel your group’s coverage under the terms of our contract with your group. If the group’s coverage is cancelled, your coverage will also be terminated on the same date. If your coverage is terminated, we will give you 30 days prior notice; and, include the reason for termination.

In addition, we may cancel your coverage for the following reasons. Coverage generally ends on the last day of the month:

- You are no longer eligible for coverage.
- You or your plan sponsor cancel coverage by completing the applicable form.
- You make any fraudulent claim(s) or misrepresentation to us or to any dentist. Examples include loaning your ID card to someone else; or putting an incorrect or incomplete statement on any form which led us to believe you were eligible for this coverage when in fact you were not. In such a case, cancellation will be as of your effective date. We will refund the premium charge we received. We will subtract from the refund any payments made for claims under this Certificate. If we have paid more for claims under this Certificate than was paid to us in premium charges, we have the right to collect the excess from you.
• The premium charge is not paid within 30 days after it is due. *Your plan sponsor* is allowed a grace period of thirty-one (31) days for the payment of any premium due except the first. The *plan sponsor* will owe *us* the premium for the period between the due date and the cancellation date. In the case of a cancellation of *your* group’s contract based on nonpayment of premiums, *we* will duly notify *you* of the cancellation in writing and will honor any claims for covered services rendered before the written notification date.

However, except for non-payment of premiums, *we* will not contest the validity of this *Certificate* after it has been in force for 2 years based on representations made to *us* before it was in force; or, unless the representation is in writing signed by *you*; and, *we* provide a copy of the statement to *you*.

**When Your Dependent's Coverage Ends**

*Your dependent's* coverage typically ends:

• When *you* become legally divorced from *your spouse*, *your former dependent spouse* will, unless specified in a court judgment, continue to be considered *your dependent* until the earliest of:
  a. the date *you* remarry, unless coverage must be provided as set forth in the divorce judgment. In that case, *your* ex-spouse can continue to be covered as a *member* of the group at an additional premium or
  b. the date *your former dependent spouse* remarries; or
  c. the date when he/she ceases to be eligible for continued coverage as specified in the divorce judgment; or
  d. the date when *you* or *your spouse* cancels coverage by completing an applicable form; or
  e. the date when *your plan* would have otherwise ended; or
  f. the date when appropriate premium payments are not made.

  * A *spouse* includes a party to a same sex marriage; civil union; or, similar union entered into under applicable state laws.

• At the end of the month in which an eligible *dependent* child marries; or

• When a *dependent* child reaches the *dependent* age limit as specified in *your plan’s Benefits Summary*.

**NOTE:** If *your* unmarried *dependent* child is mentally or physically disabled upon reaching the *dependent* age limit; and, he/she cannot earn a living, *you* may apply for continued coverage through *your plan sponsor*. *You* have 30 days from the date *your* child reaches the *dependent* age limit to apply. *You* must include the medical reason for *your* request. *We* will review *your* application to decide if it meets *our* criteria.

**NOTE:** If *your plan sponsor* purchased student coverage, *your dependent* child may be able to continue coverage past the *dependent* age. The child must be enrolled as a student. If *you* have such coverage, the option will be listed in *your* Benefits Summary with a student age limit. *Your plan sponsor determines student eligibility terms.*
Benefits After Cancellation

All services must be complete to qualify for benefits. For example, permanent crowns must be cemented; bridges or dentures must be inserted. Once your coverage is cancelled, you will not have benefits for services finished after your cancellation date. Your covered family members will not have benefits either.

When You May Rejoin the Plan

You may rejoin the same group plan after you cancel, during your group’s next open enrollment period; or, another timeframe specified by your plan sponsor. If your Plan has a waiting period, this waiting period starts again, with the new effective date. You are not allowed to reinstate your coverage.

You may join again through a different group plan. You can do this anytime you become eligible for that plan. Lifetime and annual maximums; and, claim history that accumulated while you were covered under a previous plan, or any other plan, may be carried forward to the new plan.

Features of the Plan

Your plan is designed to help you maintain good dental health through regular dental care. It will help you to pay for dental expenses. We describe your exact coverage in the Benefits Summary.

Utilization Review Guidelines

Our Dental Case Management area performs clinical claims reviews. These reviews help us decide if the service complies with our review guidelines. Analysts who review claims are registered dental hygienists; or, dental assistants with clinical experience. The analysts review claims. They can approve services. Only a dental consultant, who is a licensed dentist, can deny a claim.

We review claims using written review guidelines. We base our guidelines on accepted standards of care in the dental profession. They are backed by statistical studies of practice patterns. They also comply with guidelines approved by the Delta Dental Plans Association. These guidelines, as well as contract limits, are the basis for review decisions. We create clinical guidelines and utilization review standards with guidance from the Dental Director; in-house dental consultants; and, a dental advisory committee. The committee is made up of participating dentists. Our dental consultants and dental advisory committee study trends in dentistry; the proven value of new materials and procedures; treatment longevity; and, local and national practice patterns.

Quality Management Programs

We strive to provide high quality products and services. We do this by monitoring; identifying; and, tracking key issues over time. We deal with these issues as part of our review of our Quality Program.

Assessment of New Dental Materials and Treatments

We study new dental materials and treatments. We also study how effective they are and the cost. Then, we decide if we will cover the material or treatment.
Continuity of Care
If your dentist moves or ever decides not to participate, you can choose a new dentist from the network. There will not be any disruption in your coverage or benefits. If you change from a participating dentist to a non-participating dentist, the treatment or procedure would still be covered. This is true so long as it is a covered benefit; but, you will be responsible for any difference between our payment and the dentist’s charge.

Pre-treatment Estimate
When treatment is likely to cost more than $300, you and your dentist are strongly encouraged to get an estimate before you receive treatment. This includes treatment such as crowns; periodontic; prosthodontic; and orthodontic services.

After your dentist sends a request for an estimate, we will review the treatment plan. After reviewing the treatment plan, we will tell you and your dentist what the estimated payment will be for those services.

NOTE: Estimates are based on available benefits. The patient must be a Delta Dental member at the time the service is done. The estimate shows what money is available at the time the estimate is done. Estimates can change because services may no longer be available on the date the service is done. For example, if you had other services paid for after the estimate, and you reach your annual maximum, there will be no money left to pay for the new service. Another example is if you lose coverage before the new service is finished.

How to Use Delta Dental
Maximize Your Coverage with Participating Dentists
You have access to the nation’s largest network of dentists. The network includes general dentists and specialists. Members do not need approval from us or their general dentist to see a specialist. This includes dentists that see only children.

By choosing a dentist from the network, you get the best value from your dental plan. That’s because participating dentists agree to accept the allowance as full payment for covered services. That means that they will not bill you for any difference between the amount we allow and their actual charge.

Under your Delta Dental PPO Plus Premier plan, you can choose a participating dentist from either the PPO or Premier networks. That’s because a participating dentist may belong to the PPO network; the Premier network; or to both. Ask your dentist which network(s) he or she belongs to before receiving services. For services that require a coinsurance, you will have lower out-of-pocket costs with a PPO participating dentist. That’s because the PPO allowance is typically less than the Premier allowance.

You also have the choice of going to a dentist that is not in our network. However, when you go to a non-participating dentist, it will usually cost you more money. That’s because:

1.) You may have to pay a larger percent for services you receive.
2.) You must pay for any difference between the amount we allow and the amount the dentist charges.

3.) The amount we allow may be less than what we allow to a participating dentist.

Finding a Participating Dentist
To find a participating dentist visit our website - www.deltadentalri.com. The network includes general dentists and specialists throughout Rhode Island. In addition, members have access to participating dentists throughout the remaining states through our association with the Delta Dental Plans Association. Simply follow the directions on our website to find a participating dentist in Rhode Island or in another state. When searching for a dentist outside of Rhode Island, make sure to select either the “PPO” or “Premier” dental plan. You’ll get the names and addresses of dentists in your area; plus, maps and driving directions. You can also call Customer Service for help.

We do not require you or your dentist to get referrals to see a specialist; however, not all services done by a specialist may be covered under your plan. Check your Benefits Summary for a list of covered services. Participating dentists will file claims on your behalf; and, we will pay them directly.

Payments for Services
Participating dentists will accept your co-pay/coinsurance; plus, our payment as payment in full for covered services. We will pay participating dentists directly.

When your participating dentist provides services that are not covered; or, covered services that do not meet dental necessity criteria, as per our review guidelines; you may be liable for the dentist’s charge.

Your participating dentist may charge you more than the allowance when:

- You or your dependents receive covered services; and, you have gone over the annual maximum or lifetime maximum amount for specified services.

- You and your dentist decide to use non-covered services such as, treatments or materials that cost more than those normally given by most dentists or, that are being done to improve your appearance. In these cases, we may pay an allowance suitable for a less costly, generally accepted material or service.

Non-participating dentists do not have a contract with Delta Dental. They have not agreed to accept your co-pay/coinsurance; plus, our payment as payment in full for covered services. If you go to a non-participating dentist, your cost for services may be much more than the cost for those same services done by a participating dentist. You are also liable for the difference between our payment; and, the non-participating dentist’s charge. You will also be liable for any deductibles; copayments; and, coinsurance amounts. You may have to file your own claims; and, we usually send the benefit payments to you.

NOTE:
If you see more than one dentist for the same service; or need more than one visit, the total amount of your benefits will not be more than the amount that you would have received if only one dentist had given all of the treatment. You may be liable for the difference.

If you or your dependent has coverage for orthodontic treatment, we will make periodic payments for these covered services; spread over the expected course of the treatment. If you or your dependent is already in active treatment when you/he/she becomes eligible for these services, we will prorate our payments for the remaining treatment. Should coverage cease during active treatment, we will stop making payments as of the date the coverage ended; regardless of whether or not the treatment is complete.

Emergency Service
We cover services received in a dental office by a licensed dentist, as long as they are covered under your plan. We do not cover services received in a hospital; surgi-center; or, urgent care facility.

In the case of a life-threatening emergency, you should go to the nearest hospital. Hospital claims must be sent to your medical insurance plan. If you have an urgent dental condition, you should go to the nearest dentist's office. You do not need prior approval. We will only pay for covered services. Most dental offices treat existing patients within 24 hours for an urgent appointment. If you need help finding a participating dentist, call us at 800-843-3582. You can also find a dentist online at www.deltadentalri.com.

When Your Benefits May Be Continued

Federal Election To Continue Coverage (COBRA)
You and your dependents may have the right under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), to continue coverage through your plan sponsor. You can contact your plan sponsor about this option.

State Election to Continue Coverage
You and your dependents may have the right to continue coverage for limited periods under different state laws. Under RI COBRA rules, coverage is available in Rhode Island whenever the employment of an insured member of a group health plan (including dental) ends because of involuntary layoff or death; or, because of the workplace ceasing to exist; or, because of the permanent reduction in size of the workforce. Coverage is available to the member whose employment ended; his or her surviving spouse; and any other dependent(s) of the members who were covered under the plan. You will be charged the same monthly premium rate charged to the group.

Eligible persons may elect continuation coverage under the Plan for up to eighteen (18) months from the termination date of the insured member. Contact your plan sponsor for information about these options.
When There is Other Coverage

Right to Receive and Release Needed Information
We have the right to information related to claims filed under the plan. We can get this information from, or give it to, any organization or person with a legitimate interest. When you file a claim, you must give us any information needed to process the claim. You must give us information regarding other insurance coverage when you first enroll. You must also let your dentist know of other coverage when you receive care. We will ask you for updated information from time to time.

Coordination of Benefits
Your plan is designed to prevent overpayment of benefits when more than one Plan may cover the service. The other Plan may be a dental Plan or a medical plan that covers certain services also covered under this plan.

When you are covered by more than one Plan, one Plan is the "primary" Plan and the others are "secondary" Plans. When you file a claim, the primary Plan pays benefits first, up to the limits of the Plan. The secondary Plans adjust their benefits so that the total amount paid does not exceed the cost of covered services. This process is called "Coordination of Benefits" (COB). If you, or a family member, are also covered by other medical or dental plans, we will coordinate payment with them. We use standard insurance industry guidelines in most cases. The standard guidelines that govern this process are set forth below. If other guidelines apply to your plan, they will be noted on your Benefits Summary.

As used in these rules, the terms "Plan" and "Allowable Expenses" are defined as follows:

- "Plan" means any plan providing dental benefits or services, including government and insured or self-insured group or group-type coverages through an HMO or other prepayment, group practice or individual practice plan.

- "Allowable Expenses" means a necessary, reasonable and customary item of expense for dental care, all or part of which is covered by at least one Plan covering the person for whom the claim is made. Where a Plan provides dental benefits in the form of services rather than cash payments, the reasonable cash value of each service received will be considered both an Allowable Expense and a benefit paid.

If you are covered under more than one Plan, the total payment you receive will never be more than your Allowable Expenses.

The National Association of Insurance Commissioners sets the rules that decide which Plan is primary. They are, in part, as follows:

- The Plan without a coordination of benefits provision is primary.
- When another Plan's rules and this plan's rules require this plan to pay its benefits first, this plan is primary.
- The Plan covering the patient directly rather than as an employee's dependent is primary.
• If a child is covered under both parents' Plans, the Plan of the parent whose birthday falls earlier in the calendar year is primary (the "birthday" rule) unless the other Plan has a "gender" rule.

• If a child is covered under both parents' Plans and the other Plan has a "gender" rule, the rule in the other Plan determines benefits. (The "gender" rule says that if a child is covered under both parents' Plans, the Plan of the male parent is primary).

• If the "birthday" rule applies, and both parents have the same birthday, the Plan covering a parent longest is primary.

• If the parents are separated or divorced, benefits for the child are determined in this order:
  ♦ The Plan of the parent with custody.
  ♦ The Plan of the spouse of the parent with custody.
  ♦ The Plan of the parent not having custody, unless one of the parents is made responsible for the child's health expenses by a court decree.

• If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined above.

• If a full-time student is eligible for coverage as a dependent under this Certificate, the benefits of any other coverage available because of student enrollment (except accident-only type coverage) will be determined before the benefits under this plan.

• The benefits of a Plan which covered a person as an employee who is neither laid off nor retired are determined before those of a Plan which covers that person as a laid off or retired employee. The same is true if a person is a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

• If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the benefits are determined in the following order:
  ♦ First, the benefits of a Plan covering the person as an employee, member or subscriber (or as that person's dependent);
  ♦ Second, the benefits under the continuation coverage.
  ♦ If the other plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
  ♦ If payment responsibility is still unresolved, the Plan covering the patient longest is primary.

In general, if you exceed your benefits for a calendar year, the primary insurer will cover you up to its allowance. The secondary insurer will cover any allowable benefit you use over that amount. The insurers will never pay more than the total amount of coverage that would have been provided if benefits were not coordinated.
Subrogation
If someone caused your illness or injury, you may have the legal right to get back some of your dental care costs. When you have this right, you must let us use it if we decide to recoup any payments we made for services related to the illness or injury. If you use this right to recoup money from someone else, you must repay us for the payments we made. Our right to repayment comes first. It can be reduced only by our share of your reasonable cost of collecting your claim against the other person; or, if the payment received is for “other than dental expenses.” You must give us information and assistance and sign documents needed to help us receive our repayment. You must not do anything that might limit our repayment.

Facility of Payment
If another Plan pays a benefit that should have been paid under this plan, we may reimburse the other Plan for that amount. It will be considered a benefit paid by this plan.

Right of Recovery
If we pay more than we should have paid under the COB provison, we have the right to recoup the excess amount we paid. This includes recouping from other insurance companies and organizations. The amount that can be recouped includes the reasonable cash value of any benefits provided in the form of services.

When You Have a Claim

When to File a Claim
You should send us completed claim forms for services covered under this Certificate. You have 12 months from the date you receive services. All services must be complete to qualify for benefits; e.g., permanent crowns cemented; bridge or denture inserted. Participating dentists will submit claim forms on your behalf. You will not be responsible for payment on covered services when a participating dentist submits claims more than 12 months after the date you received the service; except, for any deductibles; copayments; coinsurance; or, amounts in excess of the annual or lifetime dollar maximums. We will deny claims that a non-participating dentist sends to us more than 12 months after you receive the services. You will be required to pay such claims, unless the failure to submit a claim within 12 months was because of a legal incapacity.

How to File a Claim

Participating Dentist
When you go to a dentist who has agreed to participate, your claim will be filed for you. It will include all necessary supporting information, such as x-rays. We accept claims from dentists on paper and in an electronic, HIPAA compliant format.

Non-participating Dentist
When you go to a dentist who is not participating, you must mail the claim to the following address. You don’t have to do this if the dentist agrees to file it for you. Dental claim forms are available on our website at www.deltadentalri.com; or, from your dentist.

MAIL CLAIMS TO: Delta Dental of Rhode Island
Claims Procedures

Call Customer Service if you have a question about how a claim paid, or why it denied. The number is **401-752-6100 or 800-843-3582.** Customer Service representatives are available Monday – Thursday from 8 a.m. to 7 p.m. E.T., and Friday from 8 a.m. to 5 p.m. E.T. You have a right to request a full and fair review of your claim. **To consider a claim for payment, we must receive it within 12 months of the date you receive the service.** We will send you a notice if we cannot process a post service claim due to missing information. (A post-service claim is filed after dental care is received). The notice will be sent to you within 30 days. It will tell you what additional information is needed to process the claim. A **participating dentist** must provide the information needed to process a claim. If not provided, the **dentist** may not charge the patient for any un-paid amount. If you or your **dentist** are located in Rhode Island, your **dentist** may speak with our dental consultants (licensed dentists) before we make an initial **adverse benefit decision** on a service that is subject to clinical review. Your **dentist** may do this by noting the request on the claim form.

**Pre-treatment Estimates**

A pre-treatment estimate is a claim that is filed before you have a dental service. When you file a pre-treatment estimate with us, we review the treatment plan. We let you and your **dentist** know, in advance, how much we will cover. When treatment is likely to cost more than $300, you and your **dentist** are strongly encouraged to get an estimate before you receive treatment. This includes treatment such as crowns; periodontic; prosthodontic; and orthodontic services.

We must have all of the information we need to review the pre-treatment estimate; and, to make a benefit decision. We will send you written notice of our initial decision. Generally, we will send this notice within 30 business days. For RI residents, or for services to be done in RI, we will send an **adverse benefit decision** notice in accordance with the timeframes set by RI law. In RI, for non-urgent and non-emergency cases, we will send an **adverse benefit decision** notice within 15 business days; and, prior to the proposed date of service. For urgent or emergency cases, we will send an **adverse benefit decision** notice within 72 hours.

If the service is denied, the notice will explain the reason(s) for the denial. The notice will include the process for filing an appeal. Once a denial is made, you have 180 days from the day you get our notice to file an appeal.

**Post-service Claims**

A post-service claim is a claim that is filed after dental care has been received. All services must be complete to qualify for benefits; e.g., permanent crowns must be cemented; bridges or dentures must be inserted. We will send you written notice of an **adverse benefit decision.** You will receive this notice within 30 calendar days of the day we receive the claim. We will send you a notice if we can’t process a post service claim because information is missing. The notice will be sent to you within 30 days. It will tell you what additional information we need to process the claim. A **participating dentist** must provide the information needed to process a claim. He/she may not charge the patient for any amount not paid if this information is not
provided. Refer to the Expedited Reviews section for claims involving emergency medical conditions.

We will pay your claim within 40 days after receipt of a complete paper claim; and, within 30 days after receipt of a complete electronic claim. A complete claim has all the supporting documentation we need to make a claim decision. If we do not pay within this time, we will pay interest on the amount not paid. Interest will be paid at a rate of 12 percent per year in accordance with applicable law.

If the service is denied, the notice will explain the reason(s) for the denial. It will include the process for filing an appeal. Once a denial is made, you have 180 days from the day you receive our notice to file an appeal.

To Appeal an Adverse Benefit Decision
If you receive an adverse benefit decision, you have the right to have it reviewed. Send us a written request for an appeal. In the case of an urgent or emergency care request, you may start an appeal by calling Customer Service. You must send your request within 180 days from the date you receive our notice. The Explanation of Benefits or Pre-treatment Estimate notice has numbered messages. These messages explain the reason(s) for the denial. They also refer to any plan terms the decision was based on; and may refer to any guideline; protocol; or, criteria we used to make the denial. You have the right to see copies of all documents related to the claim. We will also give you a copy of any internal rule; guideline; or, protocol we used. We will also explain the scientific or clinical judgment we used to decide the claim. We will give you this information, if you ask for it, at no charge.

We allow one level of internal appeal. However, if an adverse benefit decision is based on a service not being dentally necessary and appropriate, as per our review guidelines; we allow two levels of internal appeal; and, an external review.

To start the first level of internal appeal, you must do so in writing. For an urgent or emergency care request,* you may call Customer Service to start an appeal. You have 180 calendar days to make your appeal. The time starts from when you get our denial notice. Send your appeal to: Delta Dental of Rhode Island, Attn: Appeals, P.O. Box 1517, Providence, RI, 02901-1517. Your appeal should ask for reconsideration noting the reason why you believe the service was wrongly denied. It should contain a copy of the Explanation of Benefits or Pre-treatment Estimate notice. You should include the patient’s name; the subscriber identification number; clinical treatment notes; narrative; photos; x-rays; charting; and, any other necessary clinical documentation that supports your claim. To be covered, services must meet the criteria found in our review guidelines. These guidelines can be found at www.deltadentalri.com. Your appeal will be evaluated based on material in the file. If the file is incomplete, an incorrect decision could be reached. It is in your interest to add any information

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1 An “urgent care request” means a request for a service where the time periods for making a decision for a non-urgent care request: (a) could seriously risk the life or health of the insured; or, the ability of the insured to regain maximum function; or (b) in the opinion of a physician with knowledge of the insured’s medical condition, would subject the insured to severe pain that cannot be adequately managed without the service. An “emergency care request” means a request for a service where the insured has a medical condition with acute symptoms of sufficient severity. Symptoms include severe pain, such that a prudent layperson, who has an average knowledge of health and medicine, could reasonably expect that the lack of immediate medical attention would result in serious damage to bodily functions; serious failure of a bodily organ or part; or would place the person’s health at serious risk.
that is relevant to considering the appeal. A dentist will review your appeal if the first decision involved a review for dental necessity and appropriateness.

We will send you our appeal decision in writing. We will do this within 15 business days of the day we got your appeal. A decision is made within two business days, if your appeal involves an emergency medical condition. You can submit a second internal appeal, if the first appeal failed to meet dental necessity as per our review guidelines. If the claim was denied for other reasons, the internal appeals process is complete.

To start a second internal appeal, you must do so in writing. Second level appeals are only offered when the first appeal failed to meet dental necessity as per our review guidelines. For an urgent or emergency care request,* you may call Customer Service to start an appeal. You have 180 calendar days from the date you get the notice of the first appeal adverse benefit decision. Before sending a second appeal, you have the right to inspect the review file; and, add information to the file. This is the last time you will be able to add information. Additional information must be sent in writing; and, will be held confidential in accordance with applicable state and federal laws. To be covered, services must meet the criteria found in our review guidelines. These guidelines can be found at www.deltadentalri.com. Your appeal will be evaluated based on material in the file. If the file is incomplete, an incorrect decision could be reached. It is in your interest to add any information that is relevant to considering the appeal. You should follow the same process outlined above, under first level appeals. A dentist, who did not make any prior decisions on the claim, will review your appeal. For claims involving specialty services done by a specialist, a dentist skilled in the specialty area in question will review the claim. We will send you our decision in writing within 15 business days of the day we got your appeal. For appeals involving emergency medical conditions, a decision is made within two business days. The second appeal ends the internal appeals process; however, you also have the right to an external review through an independent agency. If you feel that we did not follow the appeals process as described above, you may contact the Rhode Island Department of Health’s Office of Managed Care Regulation.

To start an external appeal, you must do so in writing. You have 60 calendar days from the date you receive notice of the second appeal adverse benefit decision to send your request to us. Neither we nor you can add any information to the file that will be sent to the review agency. All documentation reviewed by our dental consultants will be sent to the review agency. External appeals are offered only when a claim is denied based on a failure to meet dental necessity and appropriateness. You must pay 50% of the cost of the external review. We pay the remaining 50%. You must include a check for your half of the cost with your request. The second appeal denial notice contains the fees for this level of appeal; or, you can call Customer Service at 800-843-3582. The review agency will contact you directly about the outcome of your appeal. If the external review agency overturns our decision, we will reimburse you within 60 days of the notice of overturn for your half of the fee.

Expedites Reviews
If your claim involves an emergency medical condition, you have the right to an expedited review. An emergency medical condition is when the insured must see a doctor right away to prevent permanent damage or death. For expedited reviews, we will complete our review; and, make a final decision within 2 business days. We have received all of the information needed to review the claim. Call Customer Service to obtain an expedited review.
Resolution of Inquiries and Complaints

Inquiries
If you have questions or concerns, send an email to customerservice@deltadentalri.com. We will try to resolve it as soon as we can. The appeals process above, describes how to appeal a claim decision.

Complaints
If you have a complaint, send an email to customerservice@deltadentalri.com; or, call us at 401-752-6100 or 800-843-3582. We settle most complaints on first contact. However, if your complaint needs more research (e.g., it involves quality of care; fraud; or, abuse, etc.), we will settle it as soon as we can. If you are not satisfied, you may call the Rhode Island Department of Health’s Office of Managed Care Regulation.

Other Provisions

Claims Review
This Certificate provides coverage only for dentally necessary and appropriate care. The decision whether a service is dentally necessary is solely for the purpose of claims payment. It is not a professional dental judgment. You have the right to appeal our decision. Refer to the Claims Procedures section, and the definition of “dentally necessary” in the Definitions section.

Although we may conduct review, we do not act as a dentist. We do not provide dental care. We do not make dental judgments. Nothing here is meant to change; or, affect your relationship with your dentist.

Access to Records
When you file a claim, you agree to give us the right to get, from any source, all dental records and/or related information that we need. We will keep your information confidential. We can also have a licensed dentist examine, at our expense, any person making a claim. You agree that dentists may give us individually identifiable health information. You also agree that we may use and disclose such information as described in our Notice of Privacy Practices. You can find this Notice on our website. You can also call Customer Service for a copy.

Participating dentists must give us all of the information we need to process your claim. They will not charge for this service. Non-participating dentists in Rhode Island must do this too.

If you get services outside Rhode Island from a non-participating dentist, you must help us get all of the records we need. We will not pay the dentist for giving us this information. If the non-participating dentist does not give us this information, we may not provide benefit payments to you.

Document Changes
We or your plan sponsor may change your Certificate. This is usually done on your group's anniversary date. Your plan sponsor will notify you. We are not responsible if he or she does
not. *Your Certificate* will be changed whether or not you have been notified by *your plan sponsor*. There will be an effective date for any change. The change will apply to all benefits for services you receive on or after the effective date. No agent or broker has authority to change or waive any of the provisions of this *Certificate*. No change in the *Certificate* shall be valid unless approved by an officer of Delta Dental of Rhode Island; and made a written part of this *Certificate* or the accompanying Benefits Summary.

**Notices**

To *You*: When we send a notice, we will send it by first class mail, e-mail or fax. Once we send the notice, we are not responsible for its delivery. It will be *your plan sponsor's* responsibility to notify you if the notice is sent to *your plan sponsor*. This applies to any bills for premium charges as well as to a notice of a change in the premium charge or a change in the *Certificate*. If your name or mailing address should change, you should notify us and *your plan sponsor* at once. Be sure to give us and *your plan sponsor* both your old name and address as well as your new name and address.

To *Us*: Email us at customerservice@deltadentalri.com or send mail to:

Delta Dental of Rhode Island  
P.O. Box 1517  
Providence, RI 02901-1517.

Always include your name; and, your ID number.

**Acts of Providers**

We will not get involved with the relationship between *dentists* and patients. We are not responsible if a *dentist* refuses to treat you. We are not liable for injuries or damages resulting from the acts or omissions of a *dentist*. We are not responsible if you are dissatisfied with the treatment or services your dentist provides.

**Right to Recover Overpayments**

If we pay more than we should, we can recoup payment from either you; or, the *dentist*. We can also deduct any payment we have made from any benefits properly paid under this policy if the payment was made:

1. In error; or  
2. Due to a misstatement in a proof of loss; or  
3. Due to fraud or misrepresentation of a material fact to procure coverage or under the terms of the coverage; or  
4. For an ineligible person; or,  
5. Due to a claim for which benefits are recoverable under any policy or act of law providing coverage for occupational injury or disease, to the extent that such benefits are recovered.

If we have already made claim payments to a covered person; we can reduce the payment we would make on a future claim to recoup an overpayment.
Legal Actions
You are not allowed to file a lawsuit against us regarding a claim for benefits until at least sixty (60) days after you have submitted the claim. Also, you may not file a lawsuit against us regarding a claim for benefits more than 3 years after you are required to submit the claim.

Conformity With Applicable Laws
We amend any term of this Certificate which conflicts with any relevant law. We do this to conform to the minimum requirements of such law.

This Certificate, and the Benefits Summary, is a description of your benefits; rights; and, your obligations under the plan.

Your subscriber ID card identifies you as a person with these benefits. Please show the ID card to your dentist whenever you or your dependents receive services.

Preexisting Conditions
There are no preexisting condition limitations in this plan.

Waiting Periods
Some dental plans require you to wait a certain amount of time before they will cover a given procedure. This is called a waiting period. If your plan has a waiting period, it will be noted on the Benefits Summary.

Services Not Covered by the Plan
Unless otherwise stated in the Benefits Summary, the following are not covered:

- Services that are not dentally necessary and appropriate according to our review guidelines. Services subject to these guidelines include, but are not limited to, root canals; crowns and related services; bridges; periodontal services; orthodontics; and, oral surgery. We will make a decision whether a service dentally necessary based on these guidelines. A service may not be covered under these guidelines even if it was recommended by a dentist. Our guidelines can be found on our website at www.deltadentalri.com. You can have your dentist send us a request for a pre-treatment estimate in advance of the service to see if the service meets our guidelines.
- Services greater than the annual maximum.
- Services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group.
- An illness or injury that we decide is employment-related.
- Services you would not have to pay for if you did not have this Certificate.
- Services or supplies that are experimental in terms of generally accepted dental standards.
- Services done by a dentist who is a member of your immediate family.
• An illness, injury or dental condition for which benefits are, or would have been available, through a government program if you did not have this Delta Dental coverage.

• Services done by someone who is not a licensed dentist or a licensed hygienist working as authorized by applicable law.

• Exams by specialists, except for periodic oral exams.

• Consultations.

• Disorders related to the temporomandibular joints (TMJ), including night guards and surgery.

• Services to increase the height of teeth or restore occlusion.

• Restorations needed because you grind your teeth or due to erosion, abrasion, or attrition.

• Services done mainly to change or to improve your appearance.

• Orthodontics.

• Occlusal guards.

• Implants.

• Bone grafts.

• Splinting and other services to stabilize teeth.

• Laboratory or bacteriological tests or reports.

• Temporary, complete dentures or temporary, fixed bridges or crowns.

• Prescription drugs.

• Guided tissue regeneration.

• General anesthesia or intravenous sedation for non-surgical extractions, diagnostic, preventive, or minor restorative services.

• General anesthesia or intravenous sedation given by anyone other than a dentist.

We can adopt; and, apply, policies that we deem reasonable when we approve the eligibility of subscribers; and, the appropriateness of treatment plans and related charges.