Delta Dental of Rhode Island

Certificate Of Coverage

Delta Dental PPO Plus Premier

Doc. Num. RI PPO Plus Premier
Effective Date: January 1, 2014

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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 "*dental necessity"* 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*.

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 s*ubscriber* 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 p*lan*.

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 w*e* 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 w*e* 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 provision, *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, y*ou* 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

P.O. Box 1517
Providence, RI 02901-1517

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. W*e* 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,[1] *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

[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.

Expedited 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. N*on-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 w*e* 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.