



MID-ATLANTIC, INC

4061 Powder Mill Road, Suite 325  
Calverton, MD 20705-3149

## Subscriber Certificate Access ePPO

for

**[ Educators Benefit Services ]**

DentaQuest Mid-Atlantic, Inc., a wholly owned subsidiary of DentaQuest Ventures, Inc., certifies that you have the right to benefits for services according to the terms of this Subscriber Certificate and the Account Dental Service Agreement. This Subscriber Certificate is part of the Account Dental Service Agreement.

ATTEST: DentaQuest Mid-Atlantic, Inc.\*

A handwritten signature in black ink that reads "Dennis J. Lyndon".

President

\*Incorporated under the laws of the State of Maryland.

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## Introduction

This Subscriber Certificate is part of the *Agreement* between your *Plan Sponsor* and DentaQuest Mid-Atlantic, (*The Plan*). We urge you to read it carefully.

The dental services described in this Subscriber Certificate (see Part II) are covered as of your *effective date*, unless your benefits are subject to a waiting period. Additionally, there are some limitations and restrictions on your coverage, which are found in Parts II and III of this Subscriber Certificate.

To qualify for benefits under this Subscriber Certificate, services must be provided by a Plan Participating Dentist. No benefits are provided under this Subscriber Certificate for services rendered by a non-participating dentist, except for services rendered under specific conditions as described in Part IV, Sections 5 and 6 of this Subscriber Certificate.

If you have any questions, or would like a complete list of covered procedures, please contact your *Plan Sponsor* or our Customer Service department.

### Subscriber's Rights and Responsibilities

As a Dental Plan subscriber, you have the right to:

- File a *grievance* or *appeal* about the dental services provided to you.
- Be provided with appropriate information about *the Plan* and its benefits, participating dentists, and policies.

You have the responsibility to:

- Ask questions in order to understand your dental condition and treatment, and follow recommended treatment instructions given by your dentist.
- Provide information to your dentist that is necessary to render care to you.
- Be familiar with *the Plan* benefits, policies and procedures, by reading our written materials, or calling our Customer Service department.

# Part I

## Definitions

**Adverse determination:** a utilization review decision by a private review agent, the Plan, or a health care provider acting on behalf of the Plan that:

- a) decides a proposed or delivered health care service which would otherwise be covered under the covered individual's Subscriber Certificate is not, or was not medically necessary, appropriate, or efficient; and
- b) may result in non-coverage of the health care service.

*Adverse determination* does not include a decision concerning a subscriber's status as a member.

**Agreement:** refers to the Account Dental Service Agreement, a contract between the Plan and your Plan Sponsor. The Account Dental Service Agreement includes the Subscriber Certificate, Member Fee Schedule, Schedule of Benefits, Group Application, Enrollment Form, rates identified in Attachment A, and any applicable Riders, Endorsements and Supplemental Agreements.

**Appeal:** a protest filed by a covered individual or a health care provider with the Plan under its internal appeal process regarding a coverage decision concerning a covered individual.

**Appeal Decision:** a final determination by the Plan that arises from an appeal filed with the Plan under its appeal process regarding a coverage decision concerning a covered individual.

**Benefit Period:** the twelve (12) month period for which any applicable deductibles or maximums apply. This twelve (12) month period is generally the calendar year unless requested otherwise by the plan sponsor. If the benefit period is not the calendar year, an amendment shall be attached to the Subscriber Certificate that specifies the benefit period, the deductible period, the carry-forward deductible and the maximum dollar amount benefit for a benefit period.

**Calendar-year deductible:** this deductible must be satisfied each calendar year.

**Carry-forward deductible:** any portion of the deductible amount that is satisfied during the last three months of the calendar year and is carried forward and applied to the following year's deductible.

**Complaint:** a protest filed with the Maryland Insurance Administration involving an adverse determination, a grievance decision, or a coverage decision concerning a covered individual.

**Coverage decision:** an initial determination by the Plan, or a representative of the Plan that results in noncoverage of a health care service. Coverage decision includes nonpayment of all or any part of a claim, but does not include an adverse determination as defined above.

**Covered dependents:** See Family Coverage definition.

**Covered individual:** a person who is eligible for and receives dental benefits. This usually includes *subscribers* and their *covered dependents*.

**Date of service:** The actual date that the service was completed. With multi-stage procedures, the date of service is the final completion date (the insertion date of a crown, for example).

**Deductible:** the portion of the covered dental expenses that the *covered individual* must pay before *the Plan's* payment begins.

**Effective Date:** the date, as shown on our records, on which your coverage begins under this Subscriber Certificate or an amendment to it.

**Family coverage:** coverage that includes you, your spouse and unmarried dependent children under nineteen (19) or twenty-seven (27) years of age, depending on the coverage purchased by the plan sponsor. Dependents who are full-time students are covered up to age twenty-three (23) through twenty seven (27), depending upon the coverage purchased by the plan sponsor. Please refer to the Schedule of Benefits for the age limitations specific to your coverage. Your or your spouse's adopted children, children under testamentary or court appointed guardianship, other than temporary guardianship of less than 12 months duration, grandchildren in your court-ordered custody who are dependent upon you, and children under your care are also covered. In addition, a physically or mentally incapacitated child over the age of nineteen (19) through twenty-seven (27), or the age of twenty three (23) through twenty seven (27) if the child is a full time student, depending upon the coverage purchased by the plan sponsor, whose incapacity began prior to the child's qualifying birthday, who is incapable of earning his or her own living, may be eligible to continue coverage under a *family coverage* if notification is made within seventy-two (72) days of the child's qualifying birthday, and by notifying the Plan and providing medical documentation to support the continuation of coverage.

**Fee Schedule:** the payment amount for the services that may be provided by *Plan Participating Dentists* under this Subscriber Certificate and is on file with the Maryland Insurance Administration. Benefits are payable in accordance with the terms and conditions of the applicable *Schedule of Benefits* and *Member Fee Schedule* (see definition below) attached to this Subscriber Certificate and in effect at the time services are rendered.

**Filing date:** the earlier of a.) five (5) days after the date of mailing; or b.) the date of receipt.

**Fracture:** the breaking off of rigid tooth structure not including crazing due to thermal changes or chipping due to attrition.

**Grievance:** a protest filed by a *covered individual*, or a *health care provider* acting on behalf of a *covered individual*, with *the Plan* through *the Plan's* internal *grievance* process regarding an *adverse determination* concerning the *covered individual*.

**Grievance decision:** a final determination by *the Plan* that arises from a *grievance* filed with *the Plan* under its internal *grievance* process regarding an *adverse determination* concerning a *covered individual*.

**Health Advocacy Unit:** the Health Education Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General.

**Health care provider:** a.) an individual who is licensed under the Health Occupations Article to provide *health care services* in the ordinary course of business or practice of a profession and is a treating provider of the *covered individual*; or b.) a hospital, as defined in Section 19-301 of the Health-General Article.

**Health care service:** a health or medical care procedure or service rendered by a health care provider that: a.) provides testing, diagnosis, or treatment of a human disease or dysfunction; or b.) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

**Individual (or single) coverage:** coverage that includes only the *subscriber*.

**Informal inquiry or complaint:** any question or concern communicated by you or on your behalf, which has not been the subject of an adverse determination.

**Member Fee Schedule:** the part of this Subscriber Certificate that, along with the Schedule of Benefits, outlines the specific coverage in effect as well as the amount, if any, that Covered Individuals may be responsible for paying towards their dental care.

**Open enrollment:** a period during which an organization allows persons not previously enrolled in the dental plan to apply for dental plan membership.

**Out of Area Emergency:** the sudden onset of dental pain, trauma, or bleeding while traveling outside the service area that could not have been predicted before leaving the plan service area.

**Plan Participating Dentist:** a licensed dentist who has entered into an agreement with the Plan to furnish services to its *covered individuals*. Services must be provided by a Plan Participating Dentist to be covered under this Subscriber Certificate, except in the specific cases as described in Part IV, Sections 5 and 6 of this Subscriber Certificate.

**Plan Sponsor:** the person or organization that is your representative if you are a *subscriber* of a group plan. In the case of an employment group subject to the Employee Retirement Income Security Act of 1974, as amended, the employer is the *Plan Sponsor* designated under that act. The *Plan Sponsor* is your agent and is not the agent of *the Plan*. The *Plan Sponsor* sends to us the subscription charge due from you and receives all notices from us for you. We will send your *Plan Sponsor* any subscription refund due to you. It is the *Plan Sponsor's* responsibility to notify you of changes.

**Private Review Agent:** a licensed, non-hospital affiliated person or entity performing *utilization review* that is either affiliated with, under contract with, or acting on behalf of *the Plan*. A *private review* agent may also perform the internal *grievance* and *appeals* processes on behalf of *the Plan*.

***Schedule of Benefits:*** the part of this Subscriber Certificate which, along with the *Member Fee Schedule*, outlines the specific coverage in effect as well as the amount, if any, that you may be responsible for paying towards your dental care.

***Subscriber:*** an employee or member certified by the *Plan Sponsor*, who is eligible to receive dental benefits.

***The Plan:*** refers to DentaQuest Mid-Atlantic.

***Urgent medical condition:*** means a condition that satisfies either of the following: (a) A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on behalf of a carrier, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in: (i) Placing the member's life or health in serious jeopardy; (ii) The inability of the member to regain maximum function; (iii) Serious impairment to bodily function; (iv) Serious dysfunction of any bodily organ or part; or (v) The member remaining seriously mentally ill with symptoms that cause the member to be a danger to self or others; or (b) A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a health care provider with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the coverage decision.

***Utilization Review:*** a system for reviewing the appropriate and efficient allocation of health care services given or proposed to be given to a patient or group of patients.

***You:*** the *subscriber* of the dental plan.

## Part II

### Benefits

*You* have the right to benefits on a non-discriminatory basis for the following services, EXCEPT as limited or excluded elsewhere in this Subscriber Certificate. The benefits are limited to a maximum dollar payment for each *covered individual* for each benefit period. The extent of your benefits is explained in the *Schedule of Benefits* and *Member Fee Schedule* your *Plan Sponsor* has purchased and which is incorporated as a part of this Subscriber Certificate.

No benefits are provided for dental services rendered by a non-participating dentist, except in the specific cases described in Part IV, Sections 5 and 6 of this Subscriber Certificate.

#### A. Diagnostic and Preventive Services

Benefits are available for the following dental services to diagnose or to prevent tooth decay and other forms of oral disease. These dental services are what most *covered individuals* receive during a routine preventive dental visit. Examples of these services include:

1. Initial oral examination (including the initial dental history and charting of teeth); once per dentist.
2. Periodic exam; once every six (6) months.
3. X-rays of the entire mouth; once every sixty (60) months.
4. Bitewing x-rays (x-rays of the crowns of the teeth); once every six (6) months or when oral conditions indicate need.
5. Single tooth x-rays; as needed.
6. Study models and casts used in planning treatment; once every sixty (60) months.
7. Routine cleaning, scaling and polishing of teeth; once every six (6) months.
8. Fluoride treatment for children under nineteen (19) years; once every six (6) months.
9. Space maintainers required due to the premature loss of teeth; only for children under age fourteen (14) and not for the replacement of primary or permanent anterior teeth.
10. Sealants on unrestored permanent molars, once per tooth for children through age fifteen (15).

## **B. Restorative Services and Other Basic Services**

Benefits are available for the following dental services to: restore decayed or *fractured* teeth with fillings; repair dentures or bridges; rebase or reline dentures; and repair or recement bridges or crowns or onlays. Examples of these services include:

1. Fillings consisting of silver amalgam and (in the case of front teeth) synthetic tooth color fillings, but limited to one filling for each tooth surface for each twenty-four (24) month period. However, synthetic (white) fillings are limited to single surface restorations for posterior teeth. Multi-surface synthetic restorations on posterior teeth will be treated as an alternate benefit and an amalgam allowance will be allowed. The patient is responsible up to the dentist's charge. No benefits are provided for replacing a filling within twenty-four (24) months of the date that the prior filling was furnished.
2. Sedative fillings; once per tooth.
3. Stainless steel crowns on deciduous (baby) teeth; once every twenty-four (24) months.
4. Simple tooth extractions.
5. General anesthesia only when necessary and appropriate for covered surgical services and when provided by a licensed, practicing dentist.
6. Repair of dentures or fixed bridges; once every twelve (12) months. Recementing of fixed bridges; once each twelve (12) months.
7. Rebase or reline dentures; once every thirty-six (36) months.
8. Tissue conditioning; two treatments every thirty-six (36) months.
9. Repair or recement crowns and onlays. Recementing is limited to once every twelve (12) months per tooth.
10. Adding teeth to existing partial or full dentures.
11. Palliative (emergency) treatment of dental pain – minor procedure.

## **C. Complex Dental Services**

Benefits are available for the following dental services and supplies to: replace missing natural teeth with artificial ones; restore severely decayed or *fractured* teeth; treat oral disease and injury involving the teeth and oral tissues with certain oral surgical procedures; treat diseased gum tissue or bone with certain periodontal services; and treat diseased teeth with certain endodontic services. Examples of these services include:

1. Certain surgical services to treat oral disease or injury. This includes surgical tooth extractions and extractions of impacted teeth.
2. Periodontal services to treat diseased gum tissue or bone including the removal of diseased gum tissue (gingivectomy) and the removal or reshaping of diseased bone (osseous surgery). Periodontic benefits are determined according to our administrative “Periodontal Guidelines.”
3. Endodontic services for root canal treatment of permanent teeth including the treatment of the nerve of a tooth, the removal of dental pulp, and pulpal therapy. Vital pulpotomy is limited to deciduous teeth.
4. Dentures and Bridges
  - Complete or partial dentures and fixed bridges including services to measure, fit, and adjust them; once each sixty (60) months.
  - Replacement of dentures and fixed bridges, but only when they cannot be made serviceable and were inserted at least sixty (60) months before replacement.
  - Temporary partial dentures as follows:
    - To replace any of the six (6) upper or lower front teeth, but only if they are installed immediately following the loss of teeth during the period of healing.
    - For the replacement of permanent teeth for *covered individuals* who are under sixteen (16) years.

#### 5. Crowns and Onlays

Crowns and onlays as follows, but only when the teeth cannot be restored with the fillings described in Section B.1 due to severe decay or *fractures*:

- Initial placement of crowns and onlays.
- Replacement of crowns and onlays; once each sixty (60) months per tooth.]

## Part III

### Limitations and Exclusions

#### 1. BENEFITS ARE PROVIDED ONLY FOR NECESSARY AND APPROPRIATE SERVICES

We will not provide benefits for a dental service that is not covered under the terms of the Subscriber Certificate. We will not provide benefits for a covered dental service that is not necessary and appropriate to diagnose or to treat your dental condition. We will not cover experimental care procedures that have not been sanctioned by the American Dental Association and for which no procedure codes have been established.

- A. To be necessary and appropriate, a service must be consistent with the prevention of oral disease or with the diagnosis and treatment on (1) those teeth that are decayed or *fractured* or (2) those teeth where supporting periodontium is weakened by disease in accordance with standards of good dental practice not solely for your convenience or the convenience of your dentist.
- B. Who determines what is necessary and appropriate under the terms of the Subscriber Certificate: That decision is made based on a review of dental records describing your condition and treatment. We may decide a service is not necessary and appropriate under the terms of the Subscriber Certificate even if your dentist has furnished, prescribed, ordered, recommended or approved the service.

#### 2. WE DO NOT PROVIDE BENEFITS FOR:

- Services provided by a non-participating dentist except in the specific cases described in Part IV, Sections 5 and 6 of this Subscriber Certificate.
- Experimental care procedures that have not been sanctioned by the American Dental Association, or for which no procedure codes have been established.
- A service or procedure that is not described as a benefit in this Subscriber Certificate.
- Services that are rendered due to the requirements of a third party, such as an employer or school.
- Travel time and related expenses.
- An illness or injury that we determine arose out of and in the course of your employment.
- A service for which you are not required to pay, or for which you would not be required to pay if you did not have coverage under this Subscriber Certificate.
- An illness, injury or dental condition for which benefits in one form or another are available, in whole or in part, through a government program or would have been available if you did not have coverage under this Subscriber Certificate. A government program includes a local, state or national law or regulation that provides or pays for dental services. It does not include

Medicaid or Medicare. We will not provide benefits if you could have received government benefits by applying for them within the appropriate agency's time limitation.

- A method of treatment more costly than is customarily provided. Benefits will be based on the least costly method of treatment.
- A separate fee for services rendered by interns, residents, fellows or dentists who are salaried employees of a hospital or other facility.
- Appointments with your dentist that you fail to keep.
- Dietary advice and instructions in dental hygiene including proper methods of tooth brushing, the use of dental floss, plaque control programs and caries susceptibility tests.
- A service rendered by someone other than a licensed dentist or a hygienist who is employed by a licensed dentist.
- Prescription drugs.
- A service to treat disorders of the joints of the jaw (temporomandibular joints).
- A service, supply or procedure to increase the height of teeth (increase vertical dimension) or restore occlusion.
- Restorations for reasons other than decay or fracture, such as erosion, abrasion, or attrition.
- Services that are meant primarily to change or to improve your appearance.
- [Occlusal guards for the treatment of disorders of the joints of the jaw or for bruxism (grinding)]
- Implants and transplants.
- Replacement of dentures, bridges, space maintainers or periodontic appliances due to theft or loss.
- Services, supplies or appliances to stabilize teeth when required due to periodontal disease such as periodontal splinting.
- Lab exams.
- Photographs.
- Laminate veneers.
- Duplicate dentures and bridges.
- Temporary, complete dentures and temporary fixed bridges or crowns.
- Stainless steel crowns on permanent teeth.
- Cast restorations, copings and attachments for installing over dentures.
- Services related to congenital anomalies. However, this exclusion does not apply to orthodontic services that may be covered by your group's orthodontic rider.
- Tooth desensitization.
- [Occlusal adjustment.]

## Part IV

### Other Contract Provisions

#### 1. BENEFIT PAYMENTS FOR SERVICES BY A *PLAN PARTICIPATING DENTIST*

The amount if any, that you may be required to pay your *Plan Participating Dentist* is explained in the *Schedule of Benefits* and *Member Fee Schedule* your *Plan Sponsor* has purchased. Payments are made directly to *Plan Participating Dentists* from *the Plan*.

#### 2. WHEN YOUR *PLAN PARTICIPATING DENTIST* MAY CHARGE YOU MORE

When your *Plan Participating Dentist* provides covered services, he or she must accept the fee as payment in full. But in the following cases you will be responsible for the difference between *the Plan* payment and the dentist's actual charge for covered services:

- A. If you have received the maximum benefit allowed for services. For example, the maximum dollar amount for a *covered individual* in a calendar year, including the service that caused you to reach the maximum.
- B. If you and your dentist decide to use services that are more expensive than those customarily furnished by most dentists, benefits will be provided towards the service with the lower fee.
- C. If you receive payment from another person or his or her insurance company for injuries he or she caused.
- D. If, for some reason, you receive services from more than one dentist for the same dental procedure or receive services that are furnished in a series during a planned course of treatment. In such a case the total amount of your benefit will not be more than the amount that would have been provided if only one dentist had furnished all the services.

#### 3. PRE-TREATMENT ESTIMATES

If your dentist expects that dental treatment will involve a series of covered services (over \$600), he or she should file a copy of the treatment plan with *the Plan* BEFORE these services are rendered to a *covered individual*. A treatment plan is a detailed description of the procedures that the dentist plans to perform and includes an estimate of the charges for each service.

Upon receipt of the treatment plan, we will notify you and your dentist about the maximum extent of your benefits for the services reported.

**IMPORTANT NOTE:** Pre-treatment estimates are calculated based on current available benefits and the patient's eligibility. Estimates are subject to modification and eligibility that apply at the time services are completed and a claim is submitted for payment. The pre-treatment estimate is NOT a guarantee of payment or a preauthorization.

#### 4. WHEN YOUR *PLAN PARTICIPATING DENTIST* IS TERMINATED

If the *Plan Participating Dentist* is terminated for any reason other than fraud, patient abuse, incompetency or loss of license status, he/she shall continue to provide dental services to complete the procedure(s) in progress for at least ninety (90) days from the date of notice of termination, as if his/her *Participating Dentist Agreement* with *the Plan* was still in effect. The Plan will compensate the dentist for such services in accordance to the terms set forth in the *Participating Dentist Agreement*.

If the *Plan Participating Dentist* terminates the *Agreement*, the *Plan Participating Dentist* shall continue to provide, for at least ninety (90) days after the date of notice of termination to *the Plan*, dental care services to a *covered individual* of the Plan for whom the *Plan Participating Dentist* was responsible for the delivery of dental care services prior to the notice of termination. If the *Plan Sponsor* has purchased benefits for orthodontic services, the *Plan Participating Dentist* will provide orthodontic treatment begun when coverage was in effect, at the rates set forth in the *Plan Participating Dentist Agreement*. Coverage shall be provided for sixty (60) days after the date coverage terminates if the dentist has agreed to or is receiving monthly payments. If the dentist has agreed to accept or is receiving quarterly payments, the dentist shall provide orthodontic treatment for sixty (60) days after the coverage terminates or until the end of the quarter, whichever is later.

#### 5. BENEFIT PAYMENTS FOR SERVICES BY A NON-PARTICIPATING DENTIST

No benefits are provided under this *Agreement* for services rendered by a non-participating dentist, except that the Plan agrees to a.) directly reimburse a member up to a maximum of \$50, less any applicable member fees, for an Out of Area Emergency as defined in this *Agreement*, and b.) provide benefits for services rendered by a Non-Participating dentist under the specific circumstances described in Sections 6 below.

If covered services are rendered to covered individuals by a Non-participating dentist under the circumstances described in Sections 5 and 6 of Part IV of this Subscriber Certificate, the Covered Subscriber is responsible for filing claims forms for reimbursement. Claims forms may be requested from the Plan and the Plan agrees to supply claims forms to covered subscribers within fifteen (15) days of receipt of such request. For more information regarding claims forms, see Part V of this Subscriber Certificate.

If during the term of this contract none of the *Plan Participating Dentists* can render necessary care and treatment to the enrollee due to circumstances not reasonably within the control of the Plan, such as complete or partial destruction of facilities, war, riot, civil insurrection,

labor disputes, or the disability of a significant number of the Plan Participating Dentists, then the enrollee may seek treatment from an independent licensed dentist of the enrollee's own choosing. The Plan will pay the enrollee for the expenses incurred for the dental services with the following limitations: The Plan will pay the enrollee for services which are listed in the patient charge schedule as No Charge, to the extent that such fees are reasonable and customary for dentists in the same geographic area; the Plan will also pay the enrollee for those services listed in the contract for which there is a copayment, to the extent that the reasonable and customary fees for such services exceed the copayment for such services as set forth in the contract. The enrollee may be required to give written proof of loss. The Plan agrees to be subject to the jurisdiction of the Maryland Insurance Commissioner in any determination of the impossibility of providing services by Plan Participating Dentists.

#### 6. REFERRAL TO SPECIALIST WHO IS A NON-PLAN PARTICIPATING DENTIST

*A covered individual* may request a referral to a specialist who is a non-Plan Participating Dentist if a.) *a covered individual* is diagnosed with a condition or disease that requires specialized dental care; and b.) *the Plan* has not contracted with a specialist with the professional training and expertise to treat the condition or disease; and c.) the specialist agrees to be reimbursed the same allowed benefit as would be provided to a specialist who is a *Plan Participating Dentist*.

In addition, *the Plan* shall, upon notice by the Maryland Department of Health and Mental Hygiene reimburse the Department for services paid for or provided by the Department for any *covered individual* provided that the services are services covered under this Subscriber Certificate.

If covered services are rendered to covered individuals by a Non-participating dentist under the circumstances described in Sections 5 and 6 of Part IV of this Subscriber Certificate, the Covered Subscriber is responsible for filing claims forms for reimbursement. For more information regarding claims forms, see Part V of this Subscriber Certificate.

To find out if your dentist participates with *the Plan* ask your dentist if he or she has an agreement with us, call our Customer Service department, visit our website, or check the directory of *Plan Participating Dentists* on file with your *Plan Sponsor*.

#### 7. WHEN YOUR COVERAGE BEGINS

Your *Plan Sponsor* will inform us when you are eligible as a *covered individual* based upon *the Plan's* underwriting guidelines. The dental services described in this Subscriber Certificate are covered as of your *effective date*, as set out in the Enrollment Form unless your benefits are subject to a waiting period or there exists some limitations or exclusions on your membership.

## 8. SUBROGATION

*You* may have a legal right to recover some costs of your dental care from someone else because another person has caused your illness or injury. When *you* have this right, *you* must allow *the Plan* the right to recover any payments it has made for the illness or injury. If *you* recover money from someone else, *you* must repay *the Plan* for the payments that it has made. The Plan's right to repayment comes first. The repayment amount can be reduced only by the Plan's share of your reasonable cost of collecting the claim against the other person, or if the payment received is described as payment for other than dental expenses. *You* are obligated to provide *the Plan* with the written authorization, information and assistance necessary to help the Plan recover its payment, and must not do anything to prohibit *the Plan* from collecting its repayment.

## 9. WE MUST HAVE ACCESS TO YOUR DENTAL RECORDS AND/OR OTHER RELEVANT RECORDS

You agree that when you claim benefits under this Subscriber Certificate, you give us the right to obtain all dental records and/or other related information that we need from any source for claims processing purposes. This information will be kept strictly confidential and is subject to federal and state privacy and confidentiality regulations.

*Plan Participating Dentists* have agreed to give us all information necessary to determine your benefits under this Subscriber Certificate and have agreed not to charge for this service.

## 10. SUBSCRIPTION CHARGE

- A. Payments: The amount of money that your *Plan Sponsor* pays to *the Plan* for your benefits under this *Agreement* is called your subscription charge. We will send your *Plan Sponsor* a bill and will expect payment in full. We are not responsible if your *Plan Sponsor* fails to pay us. This is true even if your *Plan Sponsor* has charged you for all or part of the subscription charge.
- B. Changes: We will send your *Plan Sponsor* a notice at least forty-five (45) days before any change in your subscription charge goes into effect. It is your *Plan Sponsor's* responsibility to notify you of any change in the subscription charge. Rates will not change more than once every twelve (12) months.

## 11. WE MAY CHANGE YOUR SUBSCRIBER CERTIFICATE

We will send your *Plan Sponsor* a notice each time we change all or part of your Subscriber Certificate, describing the change(s) being made. Changes to the Subscriber Certificate may include the addition or deletion of riders as well as plan design changes. We will expect your *Plan Sponsor* to notify you of the changes. We are not responsible if your *Plan Sponsor* does not notify you. Your Subscriber Certificate will be changed whether or not your *Plan Sponsor* has notified you. You can also call our Customer Service department to get

information on your plan change. Our telephone number is listed at the end of this Subscriber Certificate.

The notice will tell you the *effective date* of the change and the benefits for services you may receive on or after the *effective date*. There is one exception: If before the *effective date* of the change, you started receiving services for a procedure requiring two or more visits, we will not apply the change to services related to that procedure. If your group has purchased benefits for orthodontic services, this limitation will not apply to these benefits.

## 12. WHEN YOUR COVERAGE ENDS

There are no conversion privileges under the Subscriber Certificate. However, a *covered individual* may have the right to continue dental coverage for a period of time under federal legislation known as the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). You and covered eligible dependent family members as defined by COBRA may be entitled to continue participating in this plan for a period of time specified under law even under conditions (such as your death or termination of employment) that would otherwise make you ineligible for coverage, so long as you pay the appropriate subscription in full. No change in benefits will occur as a result of coverage under COBRA. Contact your *Plan Sponsor* for more detailed information regarding continuation of coverage.

A *covered individual* will not be eligible for coverage when any of the following occurs:

- A. The *subscriber* is no longer enrolled in the group. We will cover you under this Subscriber Certificate until your *Plan Sponsor* notifies us.
- B. Your unmarried dependent child under your *family coverage* becomes nineteen (19) or twenty seven (27) years of age or twenty three (23) through twenty seven (27) years of age if the child is a full time student (depending upon the coverage purchased by your plan sponsor), or marries, whichever comes first. However, if your unmarried dependent child is mentally or physically incapacitated, is incapable of earning his or her own living, and his or her incapacity began prior to the child's nineteenth (19<sup>th</sup>) through twenty seventh (27<sup>th</sup>) birthday or twenty third (23<sup>rd</sup>) through twenty seventh (27<sup>th</sup>) birthday if your child is a full time student, he or she may be eligible to continue coverage under a family membership. You must notify the Plan and provide medical documentation to support this continued coverage through your *Plan Sponsor* within seventy-two (72) days of your child's qualifying birthday.
- C. If you become divorced or legally separated, your spouse's coverage under existing *family coverage* will continue so long as you remain a *subscriber* of the plan and a court judgment provides for such coverage. This coverage will continue until either you or your spouse remarries, or until the date of coverage termination stated in the judgment of divorce or separation, whichever is earlier. If you remarry and your divorce judgment so provides, your former spouse will have the right, for an additional subscription, to continue to receive such benefits as are available to you by means of the issuance of a separate subscription at a single rate under the group plan.

### 13. TERMINATION OF A SUBSCRIBER CERTIFICATE

A. You or your *Plan Sponsor* may cancel your Subscriber Certificate.

1. Your *Plan Sponsor* may cancel your Subscriber Certificate for any reason. To do so, your *Plan Sponsor* must give us notice in writing at least thirty (30) days prior to the termination date.
2. You may also cancel your Subscriber Certificate through your *Plan Sponsor*. To do so, your *Plan Sponsor* must give us notice in writing within seventy-two (72) days of cancellation. If your subscription charge is paid for a period beyond your cancellation date, we will refund the subscription charge for that period to your *Plan Sponsor* provided no claim payments have been made for services rendered after your termination date. Your *Plan Sponsor* is responsible for any refunds due you.

If you cancel your Subscriber Certificate, you must wait at least one year after your cancellation before you can enroll again as a *subscriber*. You can only enroll on your group's anniversary date or when a special re-opening occurs.

B. *The Plan* may cancel your Subscriber Certificate.

1. We may cancel or not renew your *Plan Sponsor's Agreement* under the terms of our *Agreement* with your *Plan Sponsor*. If your *Plan Sponsor's Agreement* is canceled or not renewed, your coverage will automatically be terminated as of the same date.
2. We may, upon thirty (30) days notice to *you* or your *Plan Sponsor*, cancel your Subscriber Certificate under any of the following circumstances:
  - a) Subject to the Contestability of Coverage provision set forth in Part IV, Section 15 of this Subscriber Certificate, we may cancel your Subscriber Certificate if you make any fraudulent claim or material misrepresentation to us or to any dentist, such as an incorrect or incomplete statement on your application, 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 your *Plan Sponsor* the subscription charge you have paid us. We will subtract from the refund any payments made for claims under this Subscriber Certificate. If we have paid more for claims under this Subscriber Certificate than you have paid us in subscription charges, we have the right to collect the excess from you.
  - b) We may cancel your Subscriber Certificate if your plan sponsor has not paid your subscription charges, subject to the Grace Period provision under Section 17 under this Part IV. Cancellation will be effective on a date we choose, but not earlier than the subscription charge due date. The *Plan Sponsor* will owe us the subscription charge due for the period between the due date and the cancellation date. You agree that we may use your rights against the *Plan Sponsor* to collect those subscription charges.

- c) We may cancel your Subscriber Certificate if you commit any acts of physical or verbal abuse which pose a threat to a dentist, his or her employees, or employees of *the Plan*, which are unrelated to your mental or physical condition.
  - d) We may cancel your Subscriber Certificate if you have been guilty of fraudulent or unethical dealings with us.
3. For information regarding benefits after cancellation see Part IV, Section 16 of this Subscriber Certificate.

#### C. Cancellation due to loss of eligibility

Your Subscriber Certificate will be canceled when you are no longer eligible in the group through which the Subscriber Certificate was issued. If your Subscriber Certificate is canceled because you are no longer eligible, we will continue to provide benefits for ninety (90) days only if before the cancellation date you started receiving services for a procedure that requires two (2) or more visits on separate days to a dentist's office. In such a case, the benefits described in this Subscriber Certificate are available after your cancellation date for services related to that procedure. If your group has purchased benefits for orthodontic services, the coverage shall continue for sixty (60) days after the cancellation date if the orthodontist has agreed to or is receiving monthly payments or shall continue until the later of sixty (60) days after the date coverage terminates or the end of the quarter in progress, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

The termination date of this coverage shall be the date that your *Plan Sponsor* specifies in a written notice to us. The termination date will not be more than seventy-two (72) days prior to the date of notice, and there are no paid claims past the date of termination. For certain treatments, benefits will continue beyond the termination date as specified above, the Schedule of Benefits and any applicable rider(s) identified in the *Agreement*. The claims experience will be charged to the *Plan Sponsor*. The *Plan Sponsor* will be charged claims experience for the claims incurred after the effective date and prior to the date of our receipt of the *Plan Sponsor's* notice of termination.

A *Plan Participating Dentist* shall notify a *covered individual* of the termination of the *covered individual's* Subscriber Certificate and/or their Plan Sponsor's *Agreement* if the *covered individual* visits the *Plan Participating Dentist's* office when the *Plan Participating Dentist* is aware that the *covered individual's* Subscriber Certificate and/or their Plan Sponsor's *Agreement* has terminated. The *Plan Participating Dentist* shall also inform the *covered individual* of the charge for any scheduled dental services before performing the dental services.

#### 14. MISSTATEMENT OF AGE

If the age of the *subscriber*, or any of the subscriber's covered *dependents* has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

## 15. CONTESTABILITY OF COVERAGE

1. The Account Dental Service *Agreement* may not be contested, except for nonpayment of subscription charges, after it has been in force for two (2) years from its date of issue.
2. A statement made by you relating to insurability may not be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force before the contest for a period of two (2) years during your lifetime.
3. Absent fraud, each statement made by an applicant, the Plan Sponsor or you is considered to be a representation and not a warranty.
4. A statement made to effectuate insurance may not be used to avoid the insurance or reduce benefits under the Subscriber Certificate unless (a) the statement is contained in a written instrument signed by the Plan Sponsor or *covered individual*, and (b) a copy of the statement is given to the Plan Sponsor, *covered individual* or covered beneficiary of the *covered individual*.

This provision does not preclude the assertion at any time of defenses based upon the person's eligibility for coverage under the Account Dental Service *Agreement* or upon other provisions in the Account Dental Service *Agreement*.

## 16. BENEFITS AFTER CANCELLATION

If you or your *Plan Sponsor* cancels your Subscriber Certificate or if we cancel your Subscriber Certificate for any reason other than material misrepresentation, no benefits will be provided for services that you receive after the cancellation date. An exception of ninety (90) days after the cancellation date will be made for a service that began prior to the cancellation date and requires two (2) or more visits to a dentist's office.

If the *Plan Sponsor* terminates the Account Dental Service *Agreement* or the Subscriber Certificate terminates for any reason other than non-payment of the subscription charge by you or fraud or material misrepresentation by you, and the *Plan Sponsor* has purchased benefits for orthodontic services, orthodontic treatment begun while coverage is in effect shall be provided for sixty (60) days after the date coverage terminates if the dentist has agreed to or is receiving monthly payments. If the dentist has agreed to accept or is receiving quarterly payments, the dentist shall provide orthodontic treatment for sixty (60) days after the coverage terminates or until the end of the quarter, whichever is later.

If the Plan or the *Plan Participating Dentist* terminates the Participating Dentist Agreement, the *Plan Participating Dentist* will provide orthodontic treatment begun when coverage was in effect, at the rates set forth in the Participating Dentist Agreement and subject to the time limits set out above.

## 17. GRACE PERIOD

A grace period of thirty-one (31) days will be granted for payment of each subscription charge due after the first subscription charge, unless *the Plan* does not intend to renew the *Agreement* beyond the period which subscription charge has been accepted and notice of the intention not to renew is delivered to the *Plan Sponsor* at least forty-five (45) days before the subscription charge is due. During the grace period, the *Agreement* shall continue in force.

## 18. NOTICES

- A. To you: When we send a notice to your *Plan Sponsor* we will send it by first class mail. Once we mail the notice or bill we are not responsible for its delivery. It will be your *Plan Sponsor's* responsibility to notify you. This applies to a notice of a change in the subscription charge or a change in the Subscriber Certificate. If your name or mailing address should change, you should notify your *Plan Sponsor* at once. Be sure to give your *Plan Sponsor* both your old name and address as well as your new name and address.
- B. To us: Send letters to DentaQuest Mid-Atlantic, Inc., c/o DentaQuest Ventures, Inc., PO Box 9708 Boston, MA 02114-9708. Always include your name and *subscriber* identification number.

## 19. ENROLLMENT AND CONTRACT CHANGES

All enrollment applications and any additions or changes to the Subscriber Certificate are allowed ONLY when they conform to our Underwriting Guidelines. Coverage for new spouses shall be effective from the date of marriage. Newly born children, newly adopted dependent children or grandchildren shall be covered from the moment of birth or date of adoption. The date of adoption shall be the earlier of a judicial decree of adoption or the assumption of custody, pending adoption of a prospective adoptive child by a prospective adoptive parent. A minor for whom guardianship is granted by court or testamentary appointment shall be covered from the date of appointment. A child, who the court orders to be covered under a subscriber's dental coverage, shall be covered from the date of the order.

Changes to the Subscriber Certificate may result in a change in your subscription charge. If additional payments of subscription charges are required to provide coverage for the newly dependent spouse, children or grandchildren, you must notify your *Plan Sponsor*, who must then notify us, within seventy two (72) days after the date of marriage, birth, adoption or other court order or testamentary appointment. You may be required to submit proof of the court order or relationship to your *Plan Sponsor*.

If a Single coverage becomes an Employee + One, an Employee + Spouse and One Child, or an Employee + Child(ren) or Family coverage, failure to notify the *Plan* of the new dependent(s) within the seventy-two (72) days shall result in the *Plan* never recognizing coverage for the new dependent(s) during the seventy-two (72) days. The new dependent(s) may not be enrolled until the next *open enrollment* period. If an Employee + One coverage, an Employee + Spouse and One Child coverage, or Employee + Child(ren) coverage becomes

Family coverage, the first thirty-one (31) days of the seventy-two (72) days of notice are automatically covered but coverage shall end on the thirty-second (32<sup>nd</sup>) day only if you fail to notify us within the seventy-two (72) days. The new dependent(s) may not be enrolled until the next *open enrollment* period. If another family member is added to Family coverage or another child is added to the Employee + Child(ren) coverage, the *Plan* requests notification of the additional individual to facilitate claims payments.

## 20. ENROLLING DEPENDENTS

Under certain situations, dependents may be added to your coverage at any time. Qualifying events could be a result of court order, involuntary employment termination, and your spouse's death. Under those circumstances, you must notify your *Plan Sponsor* within seventy two (72) days or six (6) months (only if specified below) of the qualifying event.

a. Death of Spouse – If your spouse dies, you may add your dependent child(ren) to the coverage provided under this *Agreement* at any time and without evidence of insurability if the dependent child(ren) previously were covered under your spouse's policy or contract. You must notify the Plan Sponsor within six (6) months of this event.

b. Court Order – If you are required under a court order (whether from this state or another state that recognizes the right of the child to receive benefits under the subscriber's health coverage) to provide health coverage for a child, the *Plan* shall allow you to enroll the child under the following circumstances:

1. You shall be allowed to enroll in family members' coverage and include the child in that coverage regardless of any enrollment period restrictions.

2. If you are enrolled but do not include the child in the enrollment, we shall allow the noninsuring parent of the child, child support enforcement agency, or any other agency with authority over the welfare of the child to apply for enrollment on behalf of the child.

3. You may not terminate coverage for the child unless written evidence is provided to us that the order is no longer in effect, that the child is or will be enrolled under other reasonable dental coverage that will take effect on or before the effective date of termination, the *Plan Sponsor* has eliminated family coverage for all of its employees or the *Plan Sponsor* no longer employs you. If the *Plan Sponsor* no longer employs you, COBRA benefits shall be available under the conditions specified in Section 12 under this Part IV.

c. Involuntary Loss of Spouse's Job - If your spouse involuntarily loses his or her job other than for cause and loses dental coverage as a result, the *Plan* shall provide continuous open enrollment for a married subscriber to alter his or her enrollment to include his or her spouse or children. You must notify the Plan Sponsor within six (6) months of this event.

## 21. WHEN AND HOW BENEFITS ARE PROVIDED

Benefits will be provided ONLY for those covered services that are furnished on or after the *effective date* of this *contract*. If before a *subscriber's effective date* he or she started receiving services for a procedure that requires two or more visits, NO BENEFITS are available for services related to that procedure. If the Plan Sponsor has purchased benefits for orthodontic services, this limitation will not apply to those benefits.

In order for you to receive any of the benefits for which you may have a right, you must inform your participating dentist that you are a *covered individual* and supply him or her with your *subscriber* identification number and any necessary information needed to file your claim. If you fail to inform your participating dentist within twelve (12) months after the services are rendered, we will no longer be obligated to provide any benefits for those services.

No benefits are provided to you if you seek services from a non-participating dentist except in the specific circumstances as described in Part IV, Sections 5 and 6 in this Subscriber Certificate.

## 22. WE ARE NOT RESPONSIBLE FOR THE ACTS OF DENTISTS

We will not interfere with the relationship between dentists and patients. You are free to select any dentist. It is your responsibility to find a dentist. We are not responsible if a dentist refuses to furnish services to you. We are not liable for injuries or damages resulting from the acts or omissions of a dentist.

## 23. COORDINATION OF BENEFITS

The Plan will apply Coordination of Benefits (COB) to all the benefits described in this Agreement. The COB program applies if any Covered Individual has coverage under more than one plan that provides hospital, medical, dental or other health care benefits, including care when the Covered Individual's condition requires that he or she be admitted as an inpatient in a hospital or surgical day care center for dental services.

This program is designed to prevent people from making a profit from health care programs by collecting more than the actual charge for their covered health care services. This practice eventually leads to increased costs of health care for all. COB regulates all benefit payments for allowable expenses so that the total payments received from all plans do not exceed the total charge for those allowable expenses.

### A. Definitions:

1. **Allowable expense** means a dental service or expense, including deductibles and copayments, that is covered at least in part by any of the plans covering a person. When a plan provides benefits in the forms of services, (for example, an HMO) the reasonable

cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense.

2. **Claim determination period** means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Plan, or before the date this COB provision or a similar provision takes effect.

3. **Closed panel plan** means a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by non-panel providers, except in cases of an out of area emergency defined as being outside the plan's service area.

4. **Custodial parent** means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

5. **Plan** means an entity that provides dental benefits or services. A plan may include group insurance, closed panel or other forms of group or group-like coverage (whether insured or uninsured), hospital indemnity benefits in excess of \$200 a day, medical care components of group long-term care policies, and Medicare or other governmental benefits as permitted by law. A plan may also include indemnity programs, PPO programs, discounted fee for service programs, point of service programs, and capitation programs. A plan may not include an individual or family insurance, or other individual coverage (except for group-type insurance), amounts of hospital indemnity insurance of \$200 or less per day, school accident type coverage, benefits for non-medical components of group long-term care policies, Medicaid policies and coverage under other governmental plans unless permitted by law, and an individual guaranteed renewable specified disease policy or intensive care policy that does not provide benefits on an expense-incurred basis.

a. **Primary Plan's** benefits are determined before those of any other plan and without considering any other plan's benefits. When this Plan is primary and a Plan Participating Dentist provides treatment, the fee listed on the Fee Schedule shall be the full dentist's fee amount.

b. **Secondary Plan's** benefits are determined after those of another plan and may be reduced because of the primary plan's benefits as long as the benefit, when added to the primary plan's benefit, is not more than the total amount of the covered benefit expenses. When this Plan is secondary, the primary plan shall pay the fee that it allows for the service. This Plan shall pay the lesser of its fee listed in the Fee Schedule or the difference between the primary plan's reimbursement and the dentist's full fee.

B. Order of Benefit Determination Rules:

1. The coverage from both plans shall be coordinated so that the *covered individual* receives the maximum allowable benefit from each plan.
2. The aggregate benefit shall be more than what each plan offers individually, but no more than the total charges for the dental services received.
3. The primary plan shall pay or provide its benefits as if the secondary plan or plans did not exist.
4. A plan that does not contain a COB provision is always primary. An exception to this rule is coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits provided by the Plan Sponsor. An example of this type of coverage is a point-of-service benefit written in connection to a closed panel (capitation) panel.
5. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
6. In determining which plan is the primary and which is the secondary, the following rules shall apply and in this order:
  - a. The plan that covers the *covered individual* other than as a dependent is the primary plan. The secondary plan is the one that covers that *covered individual* as a dependent. However, if federal law requires Medicare to be a secondary plan, then this rule may be reversed.
  - b. When both plans cover the *covered individual* as a dependent child, the plan of the parent whose birthday occurs first in a calendar year should be considered as primary. The parents should be married, not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
  - c. If a determination cannot be made with the rules as set out above, the plan that has covered either of the parents for a longer time should be considered as primary. This rule shall apply if the parents have the same birthday.
  - d. If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule shall apply to claim determination periods or plan years commencing after the plan is given notice of the court decree.
  - e. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits shall be:

- 1) the plan of the custodial parent
- 2) the plan of the spouse of the custodial parent
- 3) the plan of the noncustodial parent
- 4) the plan of the noncustodial parent's spouse.

5. If one of the plans is a medical plan and the other is a dental plan, and a determination cannot be made with the rules above, the medical plan should be considered as primary.

6. Whichever plan that covered the *covered individual* as an employee, member, subscriber or retiree longer is the primary.

#### 24. RIGHT TO RECOVER OVERPAYMENTS

If we pay more than we should have under COB, then you must refund any overpayment to *the Plan*.

**IMPORTANT:** No statement in this section should be interpreted to mean that we will provide any more benefits than those already described in the Benefits Section of this Subscriber Certificate. Remember that under COB, the total of the payments made for covered health care services will not be more than the total of the allowed charges for those covered services. We will not provide duplicate benefits for the same services. If you have any questions about COB and your Subscriber Certificate, please contact our Customer Service department. The telephone number is listed at the end of this Subscriber Certificate.

#### 25. PROHIBITED REFERRALS

Maryland law prohibits the payment of any claim, bill or other demand or request for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral. One example of a prohibited referral: a health care practitioner may not refer a patient to another health care facility in which he or she or his or her immediate family owns a beneficial interest, unless the health care services or test are personally performed by or under his or her direct supervision.

#### 26. CHOICE OF LAW

This Subscriber Certificate shall be construed according to the laws of the State of Maryland. This Subscriber Certificate may be automatically revised in order to conform to statutory requirements of the laws of the State of Maryland.

#### 27. LEGAL ACTIONS

No action in law or equity will be brought to recover under this contract prior to sixty (60) days after a claim has been presented to us, nor will any such action be brought unless

brought within three (3) years from the expiration of the time within such claim submission is required.

## 28. ENTIRE AGREEMENT; CHANGES

This Subscriber Certificate, attached to the Account Dental Service *Agreement*, including the *Schedule of Benefits* and *Member Fee Schedule* and any applicable rider(s) or attachments, the Group Application and the Enrollment Form constitute the entire *Agreement*. No change in this Subscriber Certificate shall be valid until approved by an officer of *the Plan* and unless such approval be endorsed hereon or attached hereto. No agent has any authority to change this Subscriber Certificate or to waive any of its provisions.

## 29. GRIEVANCE AND APPEAL PROCEDURES FOR USE IN NON-EMERGENCY CASES

**NOTE:** *The Plan*, as used in these *grievance* and *appeals* procedures shall mean DentaQuest Mid-Atlantic or any licensed *private review agent* to which *the Plan* has delegated its internal *grievance* and *appeals* process.

1. Except in emergency cases, *the Plan* shall document an *adverse determination* in writing after the determination has been orally communicated to the *covered individual* or *health care provider* acting on behalf of the *covered individual*, and send notice of the *adverse determination* within five (5) working days after the oral communication of the determination to the *covered individual* and any *health care provider* acting on behalf of the *covered individual*.
2. Written notice of a *coverage decision* shall be sent to the *covered individual* within thirty (30) calendar days after a *coverage decision* is made.
3. A *covered individual*, or a *health care provider* acting on the member's behalf, may file a *grievance* or an *appeal* within one hundred and eighty (180) days after receipt of an *adverse determination* or *coverage decision*.
4. An *appeal* regarding a *coverage decision*, along with any supporting documentation, should be sent to:

DentaQuest Mid-Atlantic, Inc.  
C/O DentaQuest Ventures, Inc.  
PO Box 9708  
Boston MA 02114-9708  
Tel. (800) 334-6277

5. A *grievance* regarding an *adverse determination*, along with any supporting documentation, should be sent to:

P & R Dental Strategies  
395 5<sup>th</sup> Avenue, 6<sup>th</sup> Floor  
New York, NY 10016  
Tel. (212) 686-2777  
Fax (212) 686-4703

6. A final *grievance decision* will be rendered in writing within thirty (30) working days of the filing date of a *grievance* concerning services not yet rendered, or within forty-five (45) working days if the *grievance* concerns services that have already been rendered.
7. Except in emergency cases, *the Plan* shall document a *grievance decision* in writing after the decision has been orally communicated to the *covered individual* or *health care provider* acting on behalf of the *covered individual*, and send notice of the *grievance decision* within five (5) working days after the oral communication of the decision to the *covered individual* and any *health care provider* acting on behalf of the *covered individual*.
8. A final *appeal decision* will be rendered in writing to a *covered individual* and *health care provider* acting on behalf of a *covered individual* within sixty (60) working days after the date on which an *appeal* is filed.
9. Written notice containing the details of an *appeal decision* and information concerning the right to file a complaint with the Maryland Insurance Administration will be sent to a *covered individual* and *health care provider* acting on behalf of a *covered individual* within thirty (30) calendar days after the *appeal decision* is made.
10. If there is insufficient information to complete the internal *grievance* process, *the Plan* will notify the *covered individual* or *health care provider* acting on the *covered individual's* behalf within five (5) working days of the *filing date* that review of the *grievance* may not proceed unless additional information is provided. *The Plan* will assist the *covered individual* or *health care provider* in gathering the necessary information.
11. *The Plan* may extend, by no longer than 30 working days, the thirty (30) or forty-five (45) day period required for making a final *grievance decision* with written consent of the *covered individual* or *health care provider* who filed the *grievance* on the *covered individual's* behalf.
12. Adverse and *grievance decisions* are made under the direction of:

P & R Dental Strategies  
395 5<sup>th</sup> Avenue, 6<sup>th</sup> Floor  
New York, NY 10016  
Tel. (212) 686-2777  
Fax (212) 686-4703

### 30. EXPEDITED GRIEVANCE PROCEDURE FOR USE IN EMERGENCY CASES

1. An expedited review is available when an *adverse determination* involves an *emergency* case. An *emergency* case exists only when an *adverse determination* has been rendered for proposed *health care services* that have not been delivered, and the services are necessary to treat a condition or illness that, without immediate attention, would:
  - a.) Seriously jeopardize the life or health of the *covered individual* or the *covered individual's* ability to regain maximum function; or
  - b.) Cause the *covered individual* to be in danger to self or others.
2. In an *emergency* case, a decision will be rendered within twenty-four (24) hours after the *filing date* of a *grievance* by a *covered individual* or a *health care provider* acting on the *covered individual's* behalf. The *covered individual* or a *health care provider* acting on the *covered individual's* behalf will be orally notified of the decision on the day the decision is rendered. Written notice of the *grievance decision* will be provided to the *covered individual* and *health care provider* acting on the *covered individual's* behalf within one (1) day after the decision has been orally communicated to the *covered individual* or *health care provider*.
3. In an *emergency* case, the *covered individual* or *health care provider* acting on the *covered individual's* behalf may file a complaint with the Maryland Insurance Administration if a *grievance decision* is not received with twenty-four (24) hours after the *filing date*.

### 31. THE HEALTH ADVOCACY UNIT

There is help available to *covered individual* and *health care providers* who wish to dispute a decision of *the Plan* about payment for *health care services*. The *Health Advocacy Unit* can help prepare a *grievance* to file under *the Plan's* internal *grievance* procedure. The *Health Advocacy Unit* also can assist a *covered individual* in both mediating and filing an *appeal* under the internal *grievance* process. The *Health Advocacy Unit*, however, is not available to represent or accompany a *covered individual* during any proceeding of the internal *grievance* process. The *Health Advocacy Unit* may be contacted at:

Health Advocacy Unit  
Consumer Protection Division  
Office of the Attorney General  
200 St. Paul Place, 16<sup>th</sup> Floor  
Baltimore, Maryland 21202  
Phone: 410-528-1840 or toll-free: 1-877-261-8807  
Fax: 410-576-6571  
Email: [heau@oag.state.md.us](mailto:heau@oag.state.md.us)

## 32. FILING COMPLAINTS

With the Maryland Insurance Administration:

1. A *covered individual* or *health care provider* acting on the *covered individual's* behalf may file a complaint with the Maryland Insurance Administration within thirty (30) working days after receipt of a *grievance decision*, or within sixty (60) working days after receipt of an *appeal decision*.
2. A *covered individual* or a *health care provider* filing a complaint on behalf of a *covered individual* may file a complaint with the Maryland Insurance Administration without first filing a *grievance* under the internal *grievance* procedures and receiving a final decision on the *grievance* if the *covered individual* or the *health care provider* provides sufficient information and supporting documentation in the complaint that demonstrates a compelling reason to do so. The demonstration of a compelling reason includes a showing that the potential delay in the receipt of a *health care service* until after the *covered individual* or *health care provider* exhausts the internal grievance process and obtains a final decision under the *grievance* process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or the *covered individual* remaining seriously mentally ill with symptoms that cause the *covered individual* to be in danger to self or others. In a case involving *health care services* that already have been delivered, there is no compelling reason to allow a *covered individual* or a health care provider on behalf of a *covered individual* to file a complaint without first exhausting the internal *grievance* process.
3. A *covered individual*, or a *health care provider* acting on behalf of the *covered individual* member, may file a complaint with the Maryland Insurance Administration without first filing an *appeal* with *the Plan* under *the Plan's* *grievance* and *appeals* procedures, if the coverage decision involves an urgent medical condition for which care has not been rendered. See Part I of this Subscriber Certificate for definition of urgent medical condition.
4. To file a complaint with the Maryland Insurance Administration, the *covered individual* or *health care provider* acting on the *covered individual's* behalf must contact:

Maryland Insurance Administration  
Appeal and Grievance Unit  
525 St. Paul Place  
Baltimore, Maryland 21202  
Phone: 410-468-2000 or 1-800-492-6116  
Fax: 410-468-2270

### 33. FILING AN INFORMAL INQUIRY OR COMPLAINT WITH THE PLAN

If you are dissatisfied with any aspect of your dental plan coverage, dental care or *Plan Participating Dentist*, you may file an informal inquiry or complaint within ninety (90) days of the date of service or occurrence by contacting our Customer Service department at:

DentaQuest Mid-Atlantic, Inc.  
C/O DentaQuest Ventures, Inc.  
PO Box 9708  
Boston MA 02114-9708  
Tel. (800) 334-6277

We shall initially respond to the informal inquiry or complaint within twenty (20) days from the date the informal inquiry or complaint is filed. The disposition of the informal inquiry or complaint shall be communicated orally or in writing to you within thirty (30) to sixty (60) days of receipt of the informal inquiry or complaint. This period may be extended by mutual agreement.

## Part V

### Filing a Claim

#### 1. EXPLANATION OF BENEFITS (EOB)

Each time we process a claim for you under this Subscriber Certificate, a written notice will be sent to you explaining your benefits for that claim. This notice will tell you how we paid the claim or the reasons it was denied. The notice is called an Explanation of Benefits or “EOB.”

#### 2. WHO FILES A CLAIM

*Plan Participating Dentists* will file claims directly to us for the services covered by this *contract*. We will make benefit payments within thirty (30) days to them. If covered services are rendered to covered individuals by a Non-participating dentist under the circumstances described in Part IV, Sections 5 and 6 of this Subscriber Certificate, the Covered Subscriber is responsible for filing claims forms for reimbursement. Claims forms may be requested from the Plan and the Plan agrees to supply claims forms to covered subscribers within fifteen (15) days of receipt of such request. Further details on the requirements for filing claims forms are set forth in Sections 3 and 4 below.

#### 3. TIME LIMIT

All claims for benefits under the *Agreement* for services must be submitted within ninety (90) days of the date that the *covered individual* completes the service. Failure to submit the claim within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the claim within the time required, if the proof is furnished as soon as reasonably possible and, except in the absence of legal capacity of the *covered individual*, not later than one (1) year from the time the *covered individual* should have submitted the claim.

If benefits are denied because a *Plan Participating Dentist* fails to submit a claim on time, you will not be responsible for paying the dentist for the portion of the dentist’s charge that would have been a benefit under the dental plan. This applies only if the *covered individual* properly informed the *Plan Participating Dentist* that he or she was a *covered individual* by presenting his or her dental plan identification card. The *covered individual* will be responsible for his or her patient liability, if any.

#### 4. WHEN YOU FILE A CLAIM

As the Plan does not require a written request for a claims form, the covered individual may also call the Customer Service Department at 1-(800) 334-6277 to request a form. A covered individual may request a claims form at any time after services are rendered keeping in mind

that completed claims forms must be submitted to the Plan no more than ninety (90) days after services are rendered, except under circumstances set out in Section 3 above.

Within fifteen (15) days of receipt of notice, the Plan will provide the covered individual claims forms. If the covered individual does not receive a claims form within those fifteen (15) days, the covered individual will be deemed to have complied with the Plan's requirements of this contract for filing a completed claims form, if within the Time Limit under Section 3, the covered individual submits written proof covering the service, the character and the extent of the service for which the claim is made.

After we receive your completed forms, we will no later than thirty (30) days after we receive the claim (a) send you a check for your claim to the extent of your benefits under this Subscriber Certificate; or (b) send you a notice in writing of why we are not paying your claim; or (c) send you a notice in writing that in accordance with Maryland Regulation 31.10.11.11A, the legitimacy of the claim is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary to pay your claim.

If you have any questions, contact your *Plan Sponsor* or our Customer Service department. Our telephone number is listed at the end of this Subscriber Certificate.

## Part VI

### Index

This index lists the major benefits and limitations of your Subscriber Certificate. Of course, it does not list everything that is covered in your Subscriber Certificate. To understand fully all benefits and limitations you must read carefully through your Subscriber Certificate.

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