SUMMARY OF BENEFITS

Dental Blue PPO
High Plan

This policy includes coverage of pediatric dental services as required under the federal Patient Protection and Affordable Care Act.
Essential Dental Benefits for Members Under Age 19

Your Benefits

The following benefits are subject to the plan-year deductible and co-insurance (if applicable), and out-of-pocket maximum amounts shown below. Payments are based on whether you receive services from a network or non-network dentist. Please refer to the chart below for your cost share.

Many covered services have specific time limits associated with them. For example:
- Cleanings are provided only twice in twelve months.
- Fluoride treatments are provided only once per calendar quarter.

Out-of-Pocket Maximum

For in-network benefits, this plan includes an out-of-pocket maximum of $350 per member ($700 for two or more members). The money paid for the deductible and co-insurance is included in calculating the out-of-pocket maximum. The out-of-pocket maximum is the most you could pay per plan year for your share of costs for in-network covered services. Even though you pay the following costs, they do not count toward your out-of-pocket maximum: your premiums; any balance-billed charges; all dental services for members who are not eligible for pediatric essential dental benefits; and all services this Dental Blue policy does not cover.

Out-of-Network 30% Coverage
$50 Per Member/$150 Per Family Plan-Year Deductible

In-Network 50% Coverage
Out-of-Network 55% Coverage
In-Network 75% Coverage

Out-of-Pocket Maximum

When Coverage Begins

You are covered, without a waiting period, from the date you enroll in the plan. Dental benefits in this portion of the plan are provided for members until the end of the calendar month in which they turn age 19.

Orthodontic Benefits

Orthodontic benefits are available on or after your effective date. Coverage is only provided for medically necessary orthodontic care and requires prior authorization before services are provided. Orthodontic benefits are calculated using the allowed charge. You may be responsible for the co-insurance, and any difference between the Blue Cross Blue Shield payment and the dentist’s actual charge. Please see your plan description (and riders, if any) for exact coverage details.

<table>
<thead>
<tr>
<th>Preventive Benefit Group</th>
<th>Basic Benefit Group</th>
<th>Major Benefit Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
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</tr>
<tr>
<td>80% Coverage</td>
<td>55% Coverage</td>
<td>30% Coverage</td>
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<td>No Deductible</td>
<td>$50 Per Member/$150 Per Family Plan-Year Deductible</td>
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$350 Per Member ($700 for Two or More Members) In-Network Plan-Year Out-of-Pocket Maximum

Orthodontic Benefit Group

No Deductible
Coverage is only provided for medically necessary orthodontic care and requires preauthorization before services are provided. After prior authorization, you have:
- 50% coverage for in-network services
- 30% coverage for out-of-network services
- Braces for a member who has a severe and handicapping malocclusion
- Related orthodontic services for a member who qualifies

Oral Exams
- One complete initial oral exam per provider or location (includes initial history and charting of teeth and supporting structures)
- Periodic or routine oral exams; twice in 12 months
- Oral exams for a member under age three; twice in 12 months
- Limited oral exams; twice in 12 months

X-rays
- Single tooth X-rays; no more than one per visit
- Bitewing X-rays; twice in 12 months
- Full mouth X-rays; once in 36 months per provider or location
- Panoramic X-rays; once in 36 months per provider or location

Routine Dental Care
- Routine cleaning, minor scaling, and polishing of the teeth; twice in 12 months
- Fluoride treatments; once per calendar quarter
- Sealants; once per tooth in three years per provider or location (sealants over restored tooth surfaces not covered)
- Space maintainers

Fillings
- Amalgam (silver) fillings; one filling per tooth surface in 12 months
- Composite resin (white) fillings; one filling per tooth surface in 12 months

Root Canal (treatment for permanent teeth only)
- Root canals on permanent teeth; once per tooth
- Vital pulpotomy
- Retreatment of prior root canal on permanent teeth, once per tooth in 24 months
- Root end surgery on permanent teeth; once per tooth

Crowns
- Prefabricated stainless steel crowns; once per tooth (primary and permanent)

Gum Treatment
- Periodontal scaling and root planing; once per quadrant in 36 months
- Gingivectomy; once per quadrant in 36 months

Prosthetic Maintenance
- Repair of partial or complete dentures and bridges; once each 12 months
- Reline or rebase partial or complete dentures; once in 24 months

Oral Surgery
- Simple tooth extractions; once per tooth
- Erupted or exposed root removal; once per tooth
- Surgical extractions; once per tooth (approval required for complete, bony impactions)
- Other necessary oral surgery

Other Necessary Services
- Dental care to relieve pain (palliative care)
- General anesthesia for covered oral surgery
Dental Benefits for Members Age 19 and Older

Your Benefits
The following benefits are subject to the plan-year deductible and co-insurance (if applicable), and benefit maximum amounts shown below. Payments are based on whether you receive services from a network or non-network dentist. Please refer to the chart below for your cost share.

Many covered services have specific time or age limits associated with them. For example:

- Cleanings are provided only twice in twelve months.
- Periodontal cleanings are provided only once in three months after active periodontal treatment.

Benefit Maximum
This plan has a maximum amount that it will pay for covered services during a plan year, even if your need is greater. Once the amount of your dental benefits reaches the overall benefit limit of $1,250 per member, no additional dental benefits will be provided during that plan year. When this happens, you must pay the amount of the dentist’s charges above the benefit limit for any services you incur during the same plan year.

When Coverage Begins
You are covered, without a waiting period, for preventive and basic services from the date you enroll in the plan. A six-month waiting period applies to all major restorative services. You are responsible for all of the charges for any service that is subject to a waiting period if the waiting period has not been met. Dental benefits in this portion of the plan are provided for members who are not eligible for pediatric essential dental benefits.

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</tr>
<tr>
<td><strong>No Deductible</strong></td>
<td>$50 Per Member/$150 Per Family Plan-Year Deductible (In-Network and Out-of-Network Benefits Combined)</td>
<td>$1,250 Per Member Plan-Year Benefit Maximum (In-Network and Out-of-Network Benefits Combined)</td>
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**Oral Exams**
- Complete initial oral exam (includes initial history and charting of teeth and supporting structures); once in 60 months per provider or location
- Periodic or routine oral exams; twice in 12 months
- Limited oral exams; twice in 12 months

**X-rays**
- Single tooth X-rays, as needed
- Bitewing X-rays; once in 6 months
- Full mouth X-rays; once in 60 months per provider or location
- Panoramic X-rays; once in 60 months per provider or location

**Routine Dental Care**
- Routine cleaning, scaling, and polishing of the teeth; twice in 12 months
- Periodontal cleanings; once every 3 months after active periodontal treatment, not to exceed twice in 12 months if combined with routine cleanings

**Fillings**
- Amalgam (silver) fillings; one filling per tooth surface in 24 months
- Composite resin (white) fillings; one filling per tooth surface in 24 months
- Temporary fillings; one filling per tooth

**Root canal (treatment for permanent teeth only)**
- Root canals on permanent teeth; once per tooth
- Vital pulpotomy
- Retreatment of prior root canal on permanent teeth; once per tooth in 24 months
- Root end surgery on permanent teeth; once per tooth

**Gum Treatment**
- Periodontal scaling and root planing; once per quadrant in 24 months
- Periodontal surgery; once per quadrant in 36 months

**Prosthetic Maintenance**
- Repair of partial or complete dentures and bridges; once in 12 months
- Reline or rebase partial or complete dentures; once in 36 months
- Recementing of crowns, inlays, onlays, and fixed bridgework; once per tooth

**Oral Surgery**
- Simple tooth extractions; once per tooth
- Erupted or exposed root removal; once per tooth
- Surgical extractions; once per tooth (approval required for complete, boney impactions)
- Other necessary oral surgery

**Other Necessary Services**
- Dental care to relieve pain (palliative care)
- General anesthesia for covered oral surgery

**Crowns**
- Crowns; once per tooth in 84 months
- Replacement of crowns; once in 84 months
- Metallic, porcelain, and composite resin inlays or onlays; once per tooth in 84 months
- Replacement of metallic, porcelain, or composite resin inlays or onlays; once per tooth in 84 months
- Post and core buildup in addition to crown

**Tooth Replacement**
- Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 84 months
- Fixed bridges and crowns (when part of a bridge), including services to fabricate, measure, fit and adjust them; once per tooth in 84 months
- Replacement of denture and bridges, but only when they are installed at least 60 months after the initial placement and only if the existing appliance cannot be made serviceable
- Temporary partial dentures to replace any of the six upper or lower front teeth, but only if they are installed immediately after the loss of teeth and during the period of healing
Welcome to Dental Blue PPO High Plan, a dental plan designed to manage the cost of dental services. Dental Blue PPO offers a wide network of dentists. Dentists who participate with Blue Cross Blue Shield of Rhode Island and the DenteMax Network of Dentists are also part of the Dental Blue PPO Network. Using network dentists will minimize your out-of-pocket expenses.

Your Dentist
If you already have a dentist and you want to know if he or she participates in the Dental Blue PPO network, you may call the dentist, refer to the most current dental provider directory, or call Member Service at the toll-free telephone number shown on your Dental Blue ID card. If you would like help choosing a dentist, you may call the Physician Selection Service at 1-800-821-1388. You may also access the online dental provider directory at www.bluecrossma.com.

Pre-Treatment Estimates and Prior Authorizations
If your dentist expects that your dental treatment will involve covered services that will cost more than $250, he or she must send a copy of the “treatment plan” to Blue Cross Blue Shield before services are rendered. A treatment plan is a detailed description of the procedures that the dentist plans to perform and includes an estimate for the charge for each service. Once the treatment plan is reviewed, you and your dentist will be notified of the benefits available.

If your dentist has determined you will need a service that has been identified as needing prior authorization, he or she must request approval for those services to be covered prior to the services being rendered. Prior authorization services rendered without obtaining a prior authorization approval may not be covered by this plan.

You will be responsible for all charges for services not approved through the prior approval process or rendered without prior authorization.

Multi-Stage Procedures
Your dental plan provides benefits for multi-stage procedures (these are procedures that require more than one visit, such as crowns, dentures, and root canals) as long as you are enrolled under the plan on the date that the multi-stage procedure is completed. For members over age 19, a six-month waiting period applies to some services. A participating dentist will send a claim for a multi-stage procedure to Blue Cross Blue Shield for processing only after the completion date of the procedure. You will be responsible for all charges for multi-stage procedures if your plan has been cancelled before the completion date of the procedure.

How Network Dentists Are Paid
Payments are based on the allowed charge for covered services. Network dentists agree to accept the allowed charge as payment in full. You pay only your deductible and co-insurance (if applicable). In certain situations, you will have to pay the difference between the claim payment and the provider’s actual billed charge. Refer to your plan description for information about these situations.

How Non-Network Dentists Are Paid
Payments are based on the usual and customary charge. The usual and customary charge may sometimes be less than the dentist’s actual charge. If this is the case, you must pay the amount of the dentist’s actual charge that is in excess of the usual and customary charge. However, if the dentist’s actual charge is less than the usual and customary charge, your benefits will be calculated based on the dentist’s actual charge. You are also responsible for the deductible and co-insurance, if any.

If You Have to File a Claim
Network dentists will send claims to Blue Cross Blue Shield for you. Just show them your Dental Blue ID card. The payment will be sent directly to your dentist when claims are received within one year of the completed service.

If you receive care from a non-network dentist, you may have to submit the claim yourself. If you file, send the Attending Dentist’s Statement with the original itemized bills. Any benefit payment will be sent to you. You can get Attending Dentist’s Statements from Member Service.

Any claims that you file should be sent to Blue Cross Blue Shield of Massachusetts, P. O. Box 986030, Boston, MA 02298. All member-submitted claims must be submitted within two years of the date of service.

The Blue Cross Blue Shield Grievance Program is fully described in the plan description.

Dependent Benefits
This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. Please see your plan description (and riders, if any) for exact coverage details.

Other Information
Coordination of benefits, or COB, applies to plan members who are covered by another plan for health care expenses. COB ensures that payments from all health care plans do not exceed the total charges billed for covered services.

Your plan description has a subrogation clause. This does not affect the scope of benefits. It allows claim payments to be retracted when a member recovers payment for the same charges from a third party due to liability for injury.

Questions? Call The Commonwealth Health Connector at 1-877-MA-ENROLL.

You may also visit www.mahealthconnector.org or www.bluecrossma.com/getblue for more information.

Limitations and Exclusions. These pages summarize your dental plan. Your plan description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the plan description and riders will govern. For a complete list of limitations and exclusions, refer to your plan description and riders.