

Administrative Agreement  
Between The University of Akron and Anthem Blue Cross Blue Shield

Anthem Blue Cross Blue Shield has agreed to accept The University of Akron's administrative procedures regarding eligibility.

Section 2 Page D-6: Schedule of Benefits

Dependent Age Limit: dependent children will be covered until the day of their 19<sup>th</sup> birthday. From age 19 to the end of the month in which they attain age 25 they are eligible for coverage if they are an unmarried, dependent, full time student.

Section 4 – Page D-12: Eligibility and Enrollment

Special Enrollment/Special Enrollees: Paragraph 2 –The University of Akron honors no late dependent enrollees. No dependent shall be eligible to be enrolled more than 31 days after the qualifying event.



*You've made a good decision in choosing Dental Blue<sup>®</sup>*

*The University of Akron*

**For more information, visit our web site at [anthem.com](http://anthem.com)  
10/01/2008 00169360 FOH14-MB MEME**

**DNJ00099**

Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company  
An independent licensee of the Blue Cross and Blue Shield Association.  
® Registered marks Blue Cross and Blue Shield Association.

# Table of Contents

**1 Dental Certificate**

**D-1**

Underwritten by Community Insurance Company

**2 HIPAA Notice of Privacy Practices**

**M-1**

Underwritten by Community Insurance Company



*Underwritten by Community Insurance Company*

# Your Dental Certificate

# Dental Certificate of Coverage

**(herein called the "Certificate")**

Dental Blue<sup>®</sup> 200

Community Insurance Company

1351 Wm. Howard Taft

Cincinnati, OH 45206

## 1 CERTIFICATE

Welcome to Anthem Blue Cross and Blue Shield! This Certificate has been prepared by Anthem to help explain your dental care benefits. Please refer to this Certificate whenever you require dental services. It describes how to access dental care, what dental services are covered by Us, and what portion of the dental care costs you will be required to pay.

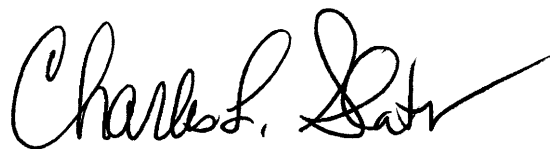
The coverage described in this Certificate is subject in every respect to the provisions of the Group Contract issued to the Group. The Group Contract and this Certificate and any amendments or riders attached to the same, shall constitute the Group Contract under which Covered Services and supplies are provided by Us.

This Certificate should be read in its entirety. Since many of the provisions of this Certificate are interrelated, you should read the entire Certificate to get a full understanding of your coverage.

Many words used in the Certificate have special meanings. These words appear in capitals and are defined for you. Refer to these definitions in the Definitions section for the best understanding of what is being stated. The Certificate also contains Exclusions.

This Dental Certificate supersedes and replaces any Dental Certificate previously issued to you under the provisions of the Group Contract.

**Read your Certificate Carefully.** The Certificate sets forth many of the rights and obligations between you and the Plan. Payment of benefits is subject to the provisions, limitations and exclusions of your Certificate. It is therefore important that you read your Certificate.



President

**Contents**

---

<b>1</b>	<b>CERTIFICATE</b> . . . . .	<b>D-3</b>
<b>2</b>	<b>SCHEDULE OF BENEFITS</b> . . . . .	<b>D-6</b>
<b>3</b>	<b>DEFINITIONS</b> . . . . .	<b>D-8</b>
<b>4</b>	<b>ELIGIBILITY AND ENROLLMENT</b> . . . . .	<b>D-10</b>
	Eligibility . . . . .	D-10
	Enrollment . . . . .	D-11
	Effective Date of Coverage . . . . .	D-13
<b>5</b>	<b>TERMINATION AND CONTINUATION</b> . . . . .	<b>D-13</b>
	Removal of Members . . . . .	D-14
	Reinstatement . . . . .	D-14
	Continuation . . . . .	D-14
	Continuation of Coverage Due To Military Service . . . . .	D-17
	Family and Medical Leave Act of 1993 . . . . .	D-17
<b>6</b>	<b>DENTAL PROVIDERS</b> . . . . .	<b>D-17</b>
<b>7</b>	<b>YOUR DENTAL BENEFITS</b> . . . . .	<b>D-18</b>
	DENTAL DEDUCTIBLES . . . . .	D-18
	DENTAL BENEFIT MAXIMUMS . . . . .	D-19
<b>8</b>	<b>HOW DENTAL BENEFITS ARE PAID</b> . . . . .	<b>D-19</b>
<b>9</b>	<b>DENTAL UTILIZATION REVIEW</b> . . . . .	<b>D-20</b>
	Pre-Treatment Review . . . . .	D-20
	Retrospective Review . . . . .	D-20
<b>10</b>	<b>DENTAL CONDITIONS OF SERVICE</b> . . . . .	<b>D-21</b>
<b>11</b>	<b>COVERED SERVICES</b> . . . . .	<b>D-21</b>
	Diagnostic and Preventive Services . . . . .	D-22
	Minor Restorative Services . . . . .	D-22
	Oral Surgery Services . . . . .	D-23
	Endodontic Services . . . . .	D-23
	Periodontal Services . . . . .	D-24
	Prosthodontics (Crowns, Inlays, Onlays) . . . . .	D-24
	Implants . . . . .	D-25
	Orthodontic Services . . . . .	D-25
<b>12</b>	<b>EXCLUSIONS</b> . . . . .	<b>D-26</b>
<b>13</b>	<b>CLAIMS PAYMENT</b> . . . . .	<b>D-29</b>
	Payment of Benefits . . . . .	D-29
	Assignment . . . . .	D-29
	Notice of Claim . . . . .	D-29
	Claim Forms . . . . .	D-29
	Proof of Claim . . . . .	D-30
	Member's Cooperation . . . . .	D-30
	Explanation of Benefits . . . . .	D-30
<b>14</b>	<b>GENERAL PROVISIONS</b> . . . . .	<b>D-30</b>
	Entire Contract . . . . .	D-30
	Form or Content of Certificate . . . . .	D-30
	Relationship of Parties (Plan - Network Dentists) . . . . .	D-30

---

Not Liable for Provider Acts or Omissions . . . . .	D-31
Identification Card . . . . .	D-31
Circumstances Beyond the Control of the Plan . . . . .	D-31
Coordination of Benefits . . . . .	D-31
Worker's Compensation . . . . .	D-34
Other Government Programs . . . . .	D-34
Subrogation and Reimbursement . . . . .	D-34
Right of Recovery . . . . .	D-35
Relationship of Parties (Group-Member-Plan) . . . . .	D-35
Conformity with Law . . . . .	D-36
Modifications . . . . .	D-36
Clerical Error . . . . .	D-36
Legal Action . . . . .	D-36
Policies and Procedures . . . . .	D-36
Waiver . . . . .	D-36
Plan's Sole Discretion . . . . .	D-36
Reservation of Discretionary Authority . . . . .	D-37
Anthem Blue Cross and Blue Shield Note . . . . .	D-37
<b>15 GRIEVANCE AND APPEAL PROCEDURES . . . . .</b>	<b>D-37</b>
Grievances . . . . .	D-37
Appeals . . . . .	D-38
Expedited Appeal and/or Expedited Independent External Review . . . . .	D-38
Grievances and Appeals by Members of ERISA Plans . . . . .	D-38

---



<b>Diagnostic and Preventive Services</b> (Not subject to the Deductible)	<u>Dental Blue 100 and 200:</u> No Coinsurance up to the maximum Covered Expense amount  <u>Dental Blue 300:</u> No Coinsurance up to the maximum Covered Expense amount. You are responsible for any charges that exceed the Covered Expense for a Dental Blue 200 Dentist.	No Coinsurance up to the maximum Covered Expense amount. You are responsible for any charges that exceed the Covered Expense.
<b>Minor Restorative Services</b>	<u>Dental Blue 100 and 200:</u> 50% Coinsurance <u>Dental Blue 300:</u> 50% Coinsurance	50% Coinsurance
<b>Oral Surgery Services</b>	<u>Dental Blue 100 and 200:</u> 50% Coinsurance <u>Dental Blue 300:</u> 50% Coinsurance	50% Coinsurance
<b>Endodontic Services</b>	<u>Dental Blue 100 and 200:</u> 50% Coinsurance <u>Dental Blue 300:</u> 50% Coinsurance	50% Coinsurance
<b>Periodontal Services</b>	<u>Dental Blue 100 and 200:</u> 50% Coinsurance <u>Dental Blue 300:</u> 50% Coinsurance	50% Coinsurance
<b>Prosthetic Services</b>	<u>Dental Blue 100 and 200:</u> 50% Coinsurance <u>Dental Blue 300:</u> 50% Coinsurance	50% Coinsurance
<b>Orthodontic Services</b>	<u>Dental Blue 100 and 200:</u> 50% Coinsurance <u>Dental Blue 300:</u> 50% Coinsurance	50% Coinsurance

Note: Removable and Fixed Appliance Therapy covered at 100%, not subject to Deductible and Coinsurance.

### 3 DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

**Accidental Injury** - Physical harm or disability that is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental Injury does not include illness or infection, except infection of a cut or wound. Damage to teeth due to chewing or biting is not an Accidental Injury.

**Actively at Work** - Present and capable of carrying out the normal assigned job duties of the Group. Subscribers who are absent from work due to a health related disability, maternity leave or regularly scheduled vacation will be considered Actively At Work.

**Annual Maximum** - The maximum dollar amount payable for Covered Services for each Member during each Benefit Period. If your benefit plan covers orthodontics, benefits for orthodontic services are not included in the Annual Maximum, but are subject to a separate lifetime maximum. Refer to the Schedule of Benefits for any Annual Maximum or lifetime maximum amounts.

**Appeal** - A formal request by you or your representative for reconsideration of an adverse decision on a Grievance or claim.

**Appliance** – A dental device used to perform a therapeutic or corrective function.

**Benefit Period** - The period of time that We pay benefits for Covered Services. The Benefit Period is listed in the Schedule of Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

**Certificate** - This summary of the terms of your benefits. It is attached to and is a part of the Group Contract and it is subject to the terms of the Group Contract.

**Coinsurance** - A percentage of the Covered Dental Expense for which you are responsible to pay. Your Coinsurance will not be reduced by refunds, rebates, or any other form of negotiated post-payment adjustments.

**Covered Expense (Covered Dental Expense)** - The dollar amount allowed by the Plan for Covered Services. The maximum Covered Expense shall be no more than:

1. For all Network Dentists, Our Dental Blue 200 Negotiated Rate; or
2. For all Non-Network Dentists, the lesser of:
  - a. the Dentist's actual charge; or
  - b. Our Dental Blue 100 Negotiated Rate.

**Covered Services** - Services or treatment as described in the Certificate which are performed, prescribed, directed or authorized by a Dentist. To be considered Covered Services, services must be:

- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Certificate is in force;
- Within the maximum Covered Expense amount;
- Medically Necessary;
- Not specifically excluded or limited by the Certificate; and
- Specifically included as a benefit within the Certificate.

**Dental Condition** – A covered Dental Condition that is not due to Accidental Injury. Dental "illness" means a disease or condition that results in damage or deterioration of sound and natural teeth, gums, or other oral tissue.

**Dental Deductible** - The dollar amount of Covered Services listed in the Schedule of Benefits for which you are responsible before We start to pay for Covered Services each Benefit Period.

**Dentist** – A person who is licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry.

**Dependent** - A person of the Subscriber's family who is eligible for coverage under the Certificate as described in the Eligibility and Enrollment section.

**Effective Date** – The date that a Subscriber's coverage begins under this Certificate. You must be Actively At Work on your Effective Date for your coverage to begin. If you are not Actively At Work on your Effective Date, your Effective Date changes to the date that you do become Actively At Work. A Dependent's coverage also begins on the Subscriber's Effective Date.

**Eligible Person** – A person who meets the Group's requirements and is entitled to apply to be a Subscriber.

**Enrollment Date** - The first day of coverage or, if there is a waiting period, the first day of the waiting period (typically the date employment begins).

**Experimental Procedures** - Procedures not yet recognized by the American Dental Association as indicated with a specific procedure code designation, or procedures which are not widely accepted as proven and effective procedures within the organized dental community.

**Grievance** - Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- the availability of Providers;
- the handling or payment of claims for dental care services;

- matters pertaining to the contractual relationship between you and the Plan or the Group and the Plan.

**Group** – The employer, or other organization, that has entered into a Group Contract with the Plan.

**Group Contract (or Contract)** – The Contract between the Plan and the Group. It includes this Certificate, your application, any supplemental application or change form, and any additional legal terms added by Us to the original Contract.

**Identification Card / ID Card** – A card issued by the Plan, showing the Member's name, membership number, and occasionally coverage information.

**Late Enrollee** – An Eligible Person whose enrollment did not occur on the earliest date that coverage can become effective under this Certificate, and who did not qualify for Special Enrollment.

**Medically Necessary (Medical Necessity)** – Medically Necessary procedures, services or treatments are those which are:

1. Appropriate and necessary for the symptoms, diagnosis, or treatment of the Dental Condition;
2. Customarily provided for the prevention, diagnosis, or direct care and treatment of the Dental Condition;
3. Within standards of good dental practice within the organized dental community;
4. Not primarily for your convenience, or the convenience of your Dentist or another Dentist; and
5. Based on prevailing dental practices, the least expensive Covered Service suitable for your Dental Condition which will produce a professionally satisfactory result.

**Member** - A Subscriber or Dependent who has satisfied the eligibility conditions, applied for coverage, been approved by the Plan and for whom Premium payment has been made. Members are sometimes called "you" and "your".

**Negotiated Rate** – The rate of payment Network Dentists agree to accept as payment in full for Covered Services. It is usually lower than their normal charge. Negotiated Rates are determined by Network Dentist agreements.

**Network Dentist** - A Dentist who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administration functions for one or more of the following three PPO networks: Dental Blue 100, Dental Blue 200, and/or Dental Blue 300.

**Non-Network Dentist** - A Dentist who has NOT entered into a contractual agreement with Us at the time services are rendered.

**Open Enrollment** - An Enrollment Period when any eligible Subscriber or Dependent of the Group may apply for this coverage.

**Plan (or We, Us, Our)** – Community Insurance Company, dba Anthem Blue Cross and Blue Shield which provides benefits to Members for the Covered Services described in this Certificate.

**Premium** - The periodic charges due which the Member or the Group must pay the Plan to maintain coverage.

**Prosthesis (Prosthetics)** – A restorative service used to replace one or more missing or broken teeth and associated tooth structures. It

includes all types of crowns, pontics, inlays, onlays, bridges, and dentures that are Covered Services.

**Provider** - A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services that are required by applicable state law to be covered when rendered by such Provider.

**Recovery** – A Recovery is money you receive from another, their insurer or from any Uninsured Motorist”, “Underinsured Motorist”, “Medical-Payments”, “No-Fault”, or “Personal Injury Protection” or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Certificate.

**Single Coverage** - Coverage for the Subscriber only.

**Subscriber** - An employee or Member of the Group who is eligible to receive benefits under the Group Contract.

**Treatment Plan** - A detailed description, submitted by the Dentist, outlining the proposed services and fees including any appropriate radiographs and diagnostic information.

## 4 ELIGIBILITY AND ENROLLMENT

You have coverage provided under this Certificate because of your employment with/membership with/retirement from the Group. You must satisfy certain requirements to participate in the Group’s benefit plan. These requirements may include probationary or waiting periods and Actively At Work standards as determined by the Group or state and/or federal law and approved by Us.

**The Group determines Eligibility for both Subscribers and Dependents. Your Eligibility requirements are described in general terms below. For more specific eligibility information, see your Human**

**Resources or Benefits Department.**

### Eligibility

The following eligibility rules apply unless you are notified by Us and the Group.

### Subscriber

To be eligible to enroll as a Subscriber, an individual must:

- Be either: An employee, Member, or retiree of the Group, and;
- Be entitled to participate in the benefit Plan arranged by the Group;
- Have satisfied any probationary or waiting period established by the Group and be Actively At Work;
- Meet the eligibility criteria stated in the Group Contract.

## Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Group and be:

- The Subscriber's spouse. Spouse refers to individuals who have contracted the legal status of a marital relationship through religious or civil solemnized marriages and complied with all the statutory requirements pursuant to applicable law; and shall not include common law marriages which may be otherwise recognized under Ohio law or other relationships between persons not legally capable of making a marriage contract under Ohio law.
- The Subscriber's or the Subscriber's spouse's unmarried children, including natural children, stepchildren, foster children, newborn children, legally adopted children, children placed in the home for adoption, and children who the Group has determined are covered under a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law).
- Unmarried children for whom the Subscriber or the Subscriber's spouse obtains custody of, is a legal guardian or as otherwise required by law.

All enrolled eligible, unmarried children will continue to be covered until the age limit listed in the Schedule of Benefits.

Eligibility will be continued past the age limit only for those already enrolled unmarried Dependents who cannot work to support themselves due to mental retardation or physical or mental handicap. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period they would become ineligible for coverage. The Plan must certify the Dependent's eligibility. The Plan must be informed of the Dependent's eligibility for continuation of coverage within 31 days after the Dependent would normally become ineligible. You must notify Us if the Dependent's marital status or tax exemption changes and they are no longer eligible for continued coverage.

The Plan may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

To obtain coverage for children, We may require that the Subscriber complete a "Dependency Affidavit" and provide Us with a copy of any legal documents awarding guardianship of such child(ren) to the Subscriber. Temporary custody is not sufficient to establish eligibility under this Certificate.

Coverage Effective Dates and enrollment requirements are described in the Group Contract.

## Enrollment

### Initial Enrollment

An Eligible Person can enroll for Single or Family Coverage by submitting an application to the Plan. The application must be received by the date stated on the Group Contract or the Plan's underwriting rules for initial application for enrollment. If We do not receive the initial application by this date, the Eligible Person can only enroll for coverage during the Open Enrollment period or during a Special Enrollment period, which ever is applicable.

If a person qualifies as a Dependent but does not enroll when the Eligible Person first applies for enrollment, the Dependent can only enroll for coverage during the Open Enrollment period or

during a Special Enrollment period, which ever is applicable.

It is important for you to know which family members are eligible to apply for benefits under Family Coverage. See the section on eligible Dependents.

### **Newborn and Adopted Child Coverage**

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days only if the Subscriber submits through the Group, or the Plan, a request to add the child under the Subscriber's Certificate. The request must be submitted within 31 days after the birth of the child. Failure to notify the Plan during this 31 day period will result in no coverage for the newborn beyond the first 31 days, except as permitted for a Late Enrollee.

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

### **Adding a Child due to Award of Legal Custody or Guardianship**

If a Subscriber or the Subscriber's spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage would start on the date the court granted legal custody or guardianship. If We do not receive an application within the 31-day period, the child will be treated as a Late Enrollee.

### **Qualified Medical Child Support Order**

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll

your child under this Certificate, We will permit your child to enroll at any time without regard to any Open Enrollment limits and shall provide the benefits of this Certificate in accordance with the applicable requirements of such order. A child's coverage under this provision will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits. Any claims payable under this Certificate will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

### **Special Enrollment/Special Enrollees**

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other dental insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Certificate, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents in the Plan, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If We receive an application to add your Dependent or an Eligible Person and Dependent more than 31 days after the qualifying event, that person is only eligible for coverage as a Late Enrollee. Application forms are available from the Plan.

### **Open Enrollment Period**

An Eligible Person or Dependent who did not request enrollment for coverage during the initial enrollment period, or during a Special Enrollment period, may apply for coverage at any time, however, will not be enrolled until the Group's next annual enrollment.

Open Enrollment means a period of time (at least 31 days prior the Group's renewal date and

31 days following) which is held no less frequently than once in any 12 consecutive months.

### **Notice of Changes**

The Subscriber is responsible to notify the Group of any changes which will affect his or her eligibility or that of Dependents for services or benefits under this Certificate. The Plan must be notified of any changes as soon as possible but no later than within 31 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status, enrollment or disenrollment in another dental plan. Failure to notify Us of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of payments from the Group for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 31 days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage. The Plan must be notified when a Member becomes eligible for Medicare.

All notifications by the Group must be in writing and on approved forms. Such notifications must include all information reasonably required to effect the necessary changes.

A Member's coverage terminates on the last day of the billing period in which the Member

ceases to be in a class of Members eligible for coverage. The Plan has the right to bill the Subscriber for the cost of any services provided to such person during the period such person was not eligible under the Subscriber's coverage.

### **Effective Date of Coverage**

For information on your specific Effective Date of Coverage under this Certificate, please see your human resources or benefits department. You can also contact Us by calling the number located on the back of your Identification (ID) Card or by visiting [www.anthem.com](http://www.anthem.com).

### **Statements and Forms**

Subscribers (or applicants for membership) must complete and submit applications or other forms or statements the Plan may reasonably request.

Applicants for membership understand that all rights to benefits under this Certificate are subject to the condition that all such information is true, correct and complete. Any material misrepresentation by a Member may result in termination of coverage as provided in the "Changes in Coverage: Termination, Continuation & Conversion" section.

### **Delivery of Documents**

We will provide an Identification Card for each Member and a Certificate for each Subscriber.

## **5 TERMINATION AND CONTINUATION**

### **Group determines eligibility for effective and term dates.**

Except as otherwise provided, your coverage may terminate in the following situations. The information provided below is general and the actual effective date of termination may vary based on your Group's agreement with Us and

your specific circumstances, such as whether Premium has been paid in full:

- If you terminate your coverage, termination will generally be effective on the last day of the billing period in which We received your notice of termination.
- Subject to any applicable continuation or

conversion requirements, if you cease to meet eligibility requirements as outlined in this Certificate, your coverage generally will terminate on the last day of the billing period. The Group and/or you must notify Us immediately if you cease to meet the eligibility requirements. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.

- If you engage in fraudulent conduct or furnish Us fraudulent or misleading material information relating to claims or application for coverage, then We may terminate your coverage. Termination is generally effective 31 days after Our notice of termination is mailed, except when indicated otherwise in the Schedule of Benefits. We will also terminate your Dependent's coverage, generally effective on the date your coverage is terminated. We will notify the Group in the event We terminate you and your Dependent's coverage.
- A Dependent's coverage will generally terminate at the end of the billing period in which notice was received by Us that the person no longer meets the definition of Dependent, except when indicated otherwise in the Schedule of Benefits.
- If coverage is through an association, coverage will generally terminate on the date membership in the association ends.
- If you elect coverage under another carrier's dental benefit plan or under any other non-Anthem plan which is offered by, through, or in connection with the Group as an option instead of this Certificate, then coverage for you and your Dependents will generally terminate at the end of the billing period for which Premium has been paid, subject to the consent of the Group. The Group agrees to immediately notify Us that you have elected coverage elsewhere.
- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's card; or

use an invalid card to obtain services, your coverage will terminate immediately upon Our written notice to the Group. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse Us for services received through such misuse.

## Removal of Members

Upon written request through the Group, a Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

## Reinstatement

You will not be reinstated automatically if coverage is terminated. Re-application is necessary, unless termination resulted from inadvertent clerical error. No additions or terminations of membership will be processed during the time your or the Group's request for reinstatement is being considered by Us. Your coverage shall not be adversely affected due to the Group's clerical error. However, the Group is liable to Us if We incur financial loss as a result of the Group's clerical error.

## Continuation

### Federal Continuation of Coverage (COBRA)

The following applies if you are covered under a Group which is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Group's dental plan. It can also become available to other Members of your family, who are covered under the Group's dental plan, when they would otherwise lose their dental coverage. For additional information about your rights and obligations under federal law under the

coverage provided by the Group's dental plan, you should contact the Group.

### **COBRA Continuation Coverage**

COBRA continuation coverage is a continuation of dental coverage under the Group's dental plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your Dependent children could become qualified beneficiaries if coverage under the Group's dental plan is lost because of the qualifying event. Under the Group's dental plan, qualified beneficiaries who elect COBRA continuation coverage may or may not be required to pay for COBRA continuation coverage. Contact the Group for Premium payment requirements.

If you are a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Group's dental plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Group's dental plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Group's dental plan because any of the following qualifying events happens:

- The parent-Subscriber dies;
- The parent-Subscriber's hours of employment are reduced;
- The parent-Subscriber's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Group's dental plan as a "Dependent child."

### **If Your Group Offers Retirement Coverage**

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Group, and that bankruptcy results in the loss of coverage of any retired Subscriber covered under the Group's dental plan, the retired Subscriber will become a qualified beneficiary with respect to the bankruptcy. The retired Subscriber's spouse, surviving spouse, and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under Group's dental plan.

### **When is COBRA Coverage Available**

COBRA continuation coverage will be offered to qualified beneficiaries only after the Group has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), then you must notify the Group of the qualifying event.

**You Must Give Notice of Some Qualifying Events**

For the other qualifying events (divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Group within 60 days after the qualifying event occurs.

**How is COBRA Coverage Provided**

Once the Group receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage.

When the qualifying event is the death of the Subscriber, the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, and the Subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Subscriber lasts until 36 months after the date of Medicare entitlement. For example, if a covered Subscriber becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be

extended.

**Disability extension of 18-month period of continuation coverage**

If you or anyone in your family covered under the Group's dental plan is determined by the Social Security Administration to be disabled and you notify the Group in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

**Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Group. This extension may be available to the spouse and any Dependent children receiving continuation coverage if the Subscriber or former Subscriber dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the spouse or Dependent child to lose coverage under the Group's dental plan had the first qualifying event not occurred.

**If You Have Questions**

Questions concerning your Group's dental plan and your COBRA continuation coverage rights should be addressed to the Group. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact

the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

## Continuation of Coverage Due To Military Service

In the event you are no longer Actively At Work due to military service in the Armed Forces of the United States, you may elect to continue health coverage for yourself and your Dependents (if any) under this Certificate in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

"Military service" means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

You may elect to continue to cover yourself and your eligible Dependents (if any) under this Certificate by notifying your employer in advance and payment of any required contribution for health coverage. This may include the amount the Employer normally pays on your behalf. If Your military service is for a period of time less than 31 days, You may not be required to pay more than the active Member contribution, if any, for continuation of health coverage.

If continuation is elected under this provision, the maximum period of health coverage under this Certificate shall be the lesser of:

1. The 18-month period (24 months if continuation is elected on or after

12/10/2004) beginning on the first date of your absence from work; or

2. The day after the date on which You fail to apply for or return to a position of employment.

Regardless whether you continue your health coverage, if you return to your position of employment your health coverage and that of your eligible Dependents (if any) will be reinstated under this Certificate. No exclusions or waiting period may be imposed on you or your eligible Dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

## Family and Medical Leave Act of 1993

A Subscriber who is taking a period of leave under the Family and Medical Leave Act of 1993 (the Act) will retain eligibility for coverage during this period. The Subscriber and his or her Dependents shall not be considered ineligible due to the Subscriber not being Actively At Work.

If the Subscriber does not retain coverage during the leave period, the Subscriber and any eligible Dependents who were covered immediately prior to the leave may be reinstated upon return to work without medical underwriting and without imposition of an additional waiting period for Pre-Existing Conditions. To obtain coverage for a Subscriber upon return from leave under the Act, the Group must provide the Plan with evidence satisfactory to Us of the applicability of the Act to the Subscriber, including a copy of the health care Provider statement allowed by the Act.

## 6 DENTAL PROVIDERS

You do not have to select a particular Dentist to receive dental benefits. You have the freedom to choose what Dentist you want to utilize to access

Covered Services. **However, your Dentist choice (Network Dentist (Dental Blue 100, Dental Blue 200, or Dental Blue 300) or**

**Non-Network Dentist) can make a difference in the amount you pay.**

**Network Dentists.** We have established a network of various types of Network Dentists. These Dentists are called “Network” because they have agreed to participate in Our contracted Preferred Provider Organization (PPO) network(s). They have agreed to provide you with dental care at a Negotiated Rate.

There are three PPO network choices: Dental Blue 100, Dental Blue 200, and Dental Blue 300.

- Dental Blue 100 and Dental Blue 200 Network Dentists have signed an agreement with Us to accept the Dental Blue 200 Negotiated Rate as payment in full for Covered Services. You will normally receive the greatest level of benefits available for Covered Services under this Plan when you seek treatment from a Dental Blue 100 or Dental Blue 200 Network Dentist.
- Dental Blue 300 Dentists have signed an agreement with Us to provide Covered Services to Dental Blue 200 Members at a

reduced rate. If you choose to receive treatment from a Dental Blue 300 Network Dentist, you will be responsible for any difference between the Dental Blue 200 Negotiated Rate and the Dental Blue 300 Negotiated Rate. This additional amount is called protected balance billing.

**To find a Network Dentist, please access Our web site at [www.anthem.com](http://www.anthem.com) or call Our Customer Service Department at (866) 589-0578.**

### Non-Network Dentists

Non-Network Dentists are Dentists who have not agreed to participate in Our Preferred Provider Organization (PPO) network. They have not agreed to the Negotiated Rates and other provisions of a Preferred Provider Organization contract. The amount of benefits payable under this Certificate will be different for Non-Network Dentists than for Network Dentists.

## 7 YOUR DENTAL BENEFITS

We will pay for Covered Dental Expense you incur while covered under this plan, subject to all terms, conditions, limitations and exclusions specified in this Certificate.

After We subtract the Dental Deductible from the total amount of Covered Expense, We will pay benefits at the payment rate which applies to such expense, up to the applicable dental benefit maximums. The Deductible amount, Coinsurance, and dental benefit maximums are set forth in the Schedule of Benefits

### DENTAL DEDUCTIBLES

Only charges that are considered Covered Expense will apply toward satisfaction of the Dental Deductibles.

**Member Dental Deductible.** Each Benefit

Period, you will be responsible for satisfying the Dental Deductible before We begin to pay benefits under the Plan.

**Family Dental Deductible.** If enrolled Members of a family pay Dental Deductible expense during a Benefit Period equal to the Family Dental Deductible amount shown in the Schedule of Benefits, then the Dental Deductible for all Insured Family Members is considered to have been met. No further Dental Deductible is required for the remainder of that year. For the purposes of the Family Dental Deductible, Covered Dental Expense over a Member’s Dental Deductible will not be counted toward the Family Dental Deductible.

## DENTAL BENEFIT MAXIMUMS

**Annual Maximum.** Your combined benefits, are subject to the Benefit Period Maximum shown in the Schedule of Benefits. We will not pay any benefit in excess of that amount for Covered Dental Expense incurred during a Benefit Period for each Member. In addition, all payments are subject to any waiting periods, limitations, and exclusions specified in this Certificate.

**Orthodontic Services Lifetime Maximum.** Your orthodontic benefits are subject to the Orthodontic Services Lifetime Maximum shown in the Schedule of Benefits. We will not pay any orthodontic benefits in excess of that amount during a Member's lifetime. In addition, all payments are subject to any waiting periods, limitations, and exclusions specified in this Certificate.

## 8 HOW DENTAL BENEFITS ARE PAID

**Network Dentists.** You are responsible to pay the Network Dentist Coinsurance amounts listed in the Schedule of Benefits if Covered Services are provided by a Network Dentist. You have an incentive under this Plan to seek treatment from a Dental Blue 200 Network Dentist. If you choose to receive services from a Dental Blue 300 Network Dentist, you will incur additional charges over and above your Dental Deductible and Coinsurance amounts. These additional charges are the difference between the Dental Blue 200 Negotiated Rates and the Dental Blue 300 Negotiated Rates. This difference is called "protected balance billing".

Protected balance billing is a plan feature that limits out-of-pocket expenses should you choose to receive Covered Services from a Dental Blue 300 Network Dentist or if you receive a non-Covered Service from a Network Dentist.

- Covered Services. If you receive Covered Services from a Dental Blue 300 Network Dentist, the Dentist can bill you for the difference between the Dental Blue 200 Negotiated Rates and the Dental Blue 300 Negotiated Rates. Negotiated Rates are typically lower than the Network Dentist's usual billed charges.
- Non-Covered Services. Network Dentists have agreed to accept the Negotiated Rate for all services, whether the services are covered or not. If a Network Dentist provides a non-Covered Service to you, you are responsible to pay only for the

Negotiated Rate, which is typically lower than the Dentist's usual billed charge.

Please refer to your Identification Card to verify that you are a member of Dental Blue 200. If you are uncertain which Network Dentists will provide you with the lowest out-of-pocket expense, please contact customer service at the toll-free number indicated on your Identification Card or visit online at [www.anthem.com](http://www.anthem.com).

**Non-Network Dentists.** Your Coinsurance will be based on the Non-Network Dentist percentages if Covered Services are provided by a Non-Network Dentist. The protected balance billing feature does **not** apply to services provided by Non-Network Dentists. A Non-Network Dentist can charge their usual billed charges for services rendered.

### SUMMARY OF COSTS

#### If you receive treatment from a Dental Blue 200 Network Dentist:

- Coinsurance will be based on the Network Dentist percentages listed in the Schedule of Benefits.
- You are responsible for any Coinsurance, Dental Deductibles, non-Covered Services, and any amounts over the dental benefit maximums as outlined in the Schedule of Benefits.

#### If you receive treatment from a Dental Blue 300 Network Dentist:

- Coinsurance will be based on the Network Dentist percentages listed in the Schedule of Benefits.
- You are responsible for any Coinsurance, Dental Deductibles, non-Covered Services, and any amounts over the dental benefit maximums as outlined in the Schedule of Benefits PLUS any applicable protected balance billing amounts.

**If you receive treatment from a Non-Network Dentist:**

- Coinsurance will be based on the Non-Network Dentist percentages listed in the Schedule of Benefits.
- You are responsible for any Coinsurance, Dental Deductibles, non-Covered Services, and any amounts over the dental benefit maximums as outlined in the Schedule of Benefits, PLUS any amount which exceeds the Covered Dental Expense. The protected balance billing feature does not apply.

## 9 DENTAL UTILIZATION REVIEW

Dental utilization review is a process designed to promote the delivery of cost-effective dental care by encouraging the use of clinically recognized and proven procedures. Dental utilization review is included in your dental benefits to encourage you to utilize your dental benefits in a cost-effective and clinically recognized manner. Your right to benefits for Covered Services provided under this Certificate is subject to certain policies, guidelines and limitations, including, but not limited to, Our coverage guidelines, dental policy and utilization review features.

Dental utilization review is accomplished through pre-treatment review and retrospective review. Our dental coverage guidelines for pre-treatment review and retrospective review are intended to reflect the standards of care for dental practice and state-specific regulations. The purpose of dental coverage guidelines is to assist in the interpretation of Medical Necessity. In order to be Covered Services under this Certificate, services must meet the Medically Necessary requirements.

### Pre-Treatment Review

You may have a pre-treatment review done before you receive benefits. Pre-treatment review is not a prior authorization for services but is a system that allows you and your Dentist to know, in advance, what the estimated benefits payable

would be under this Certificate for a proposed course of treatment. The actual benefits you receive under the plan will be determined once a claim for services has been received and may vary from the estimated benefits based upon the actual services received as well as the benefit coverage in effect on the date(s) of services.

Under pre-treatment review, your Dentist prepares a request for a pre-treatment benefit estimation form, and submits this form to Us before any treatment begins. The pre-treatment benefit estimation form should: (a) list the recommended dental services; and (b) show the charge for each dental service. We will review this request and send a copy of Our estimated benefits to you and your Dentist. We may request supporting pre-operative x-rays or other diagnostic records in connection with the pre-treatment review. A pre-treatment review is recommended if the proposed course of treatment is expected to involve charges of **\$350 or more**.

If the course of treatment is not reviewed before treatment is received, it will be reviewed when the claim is submitted to Us for payment.

### Retrospective Review

Retrospective review means a Medical Necessity review that is conducted after dental care services have been provided. A claim review includes, but is not limited to, an evaluation of reimbursement

levels, accuracy of documentation, accuracy of coding and adjudication of payment.

We provide a toll-free telephone number available during normal business hours to assist you or your Dentist in obtaining information with respect to Our utilization review process. This same number may be utilized after business hours to leave a message which will be responded to within two business days in non-emergency situations.

If a Member disagrees with a utilization review decision and wishes to file a Grievance, or appeal a decision previously made you will find details on how to do this in the Grievance and Appeals section of this Certificate. You may also contact Our customer service number on your ID card.

The utilization review process is governed by laws and regulations, and may be modified from time to time by Us as those laws and regulations may require.

## 10 DENTAL CONDITIONS OF SERVICE

The following conditions of service must be met for an expense incurred to be considered a Covered Dental Expense.

1. You must incur this expense while you are covered for dental benefits under this Certificate. The expense is incurred on the date you receive the service or treatment for which the charge is made, except that for:
  - a. Dentures and other similar Prosthetic devices: all expenses are incurred on the date the final impression is made.
  - b. Fixed bridges, crowns, inlays, or onlays: all expenses are incurred on the date a tooth is first prepared.
  - c. Root canal therapy: all expenses are incurred on the later of the dates that the pulp chamber is opened or a canal is explored to the apex.
  - d. Periodontal surgery: all expenses are incurred on the date that the surgery is actually performed.
2. The service must be provided by a licensed Provider and must be for preventive dental care or for treatment of dental disease, defect or injury.
3. The expense must be incurred for a dental service or treatment that is included under the section Covered Services. Additional limits on Covered Dental Expense are included under specific benefits in the "Schedule of Benefits."
4. The expense must not be for a dental service or treatment listed in the Exclusions section. If the service or treatment is partially excluded, then only that portion which is not excluded will be considered Covered Dental Expense.
5. The expense must not exceed any of the dental benefit maximums or limitations of this Certificate.

## 11 COVERED SERVICES

This section describes the Covered Services available under your dental care benefits when provided and billed by Providers. All Covered Services are subject to the terms, limitations, and exclusions listed in this Certificate. The amount payable for Covered Services varies depending on

whether you receive your care from a Network Dentist or a Non-Network Dentist.

## Diagnostic and Preventive Services

- **Oral Evaluations.** Limited to two per Benefit Period in any combination of the following types of evaluations: periodic, limited, comprehensive, perio evaluations, and office visits for observation only. Limited (emergency) exams are covered as a separate procedure only if no other service (other than x-rays) is performed on the same date of service.
- **Palliative (Emergency) Treatment for Dental Pain.** Limited to twice per Benefit Period (not covered when performed in conjunction with other dental treatment or examination).
- **Office visit for observation.** Limited to two visits per Benefit Period in combination with other covered oral evaluations. Not covered when performed in conjunction with other services or procedures.
- **Bitewing Radiographs.** Limited to twice per Benefit Period.
- **Vertical Bitewings.** Limited to twice per Benefit Period.
- **Periapical X-rays.** Limited to single film plus one additional film per day.
- **Intraoral occlusal film.** Limited to one film per day.
- **Complete Series (panoramic film or full-mouth radiographs).** Limited to once every 3 years. Complete series radiographs include bitewings, and will count as one occurrence for that Benefit Period. Nine or more radiographs in any combination of periapical, occlusal, and bitewing radiographs will be considered a complete series.
- **Adult Prophylaxis.** Limited to a total of two per Benefit Period, singly or in combination with periodontal maintenance procedures (See "Periodontal Services" later in this section). Allowance includes cleaning, scaling and polishing the teeth.

- **Child Prophylaxis.** Limited to two per Benefit Period. Allowance includes cleaning, scaling and polishing the teeth.
- **Fluoride Treatments (topical application).** Limited to two per Benefit Period for dependent children up to the age of 19.
- **Sealants,** for unrestored permanent 1st and 2nd molars. Limited to one application per tooth and one replacement per tooth if replacement is performed at least 36 months after initial application. Covered only for dependent children up to the age of 17.
- **Space Maintainers.** Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes initial Prosthesis only and all adjustments within six months of placement.
- **Recement Space Maintainers.**
- **Consultations** (diagnostic service provided by a Dentist other than practitioner providing treatment). Limited to once per Benefit Period.

## Minor Restorative Services

For services to restore a tooth using a crown, see "Prosthodontic Services" later in this section. The following are covered minor restorative services under this Certificate.

- **Amalgam or composite resin restorations.** Limited to twice per surface per tooth per Benefit Period. Replacement of existing restoration is allowed no more than once every 12 months.
- **Pin retention.** Limited to once per tooth in any 12 month period (regardless of the number of pins per tooth). Pin retention must be performed on the same date of service and in conjunction with a covered amalgam or composite restoration.

- **Sedative filing.**

**Note:** Multiple surfaces billed on the same tooth for the same date of service are combined and paid as one restoration.

## Oral Surgery Services

For surgical procedures related to the gums and to the bone that supports teeth, see "Periodontal Services" later in this section. Covered oral surgery includes:

- **Extraction of coronal remnants, primary tooth**
- **Extraction, erupted tooth or exposed root**
- **Surgical removal of erupted tooth**
- **Removal of impacted tooth, soft tissue, partially bony, and completely bony**
- **Surgical removal of residual tooth roots**
- **Oroantral fistula closure**
- **Primary closure of sinus perforation**
- **Removal of lateral exostosis**
- **Removal of torus, palatinus and mandibularis**
- **Surgical reduction of osseous tuberosity**
- **Alveoloplasty**
- **Vestibuloplasty**
- **Biopsy of oral tissue, hard and soft**
- **Frenulectomy, frenuloplasty**
- **Excision of hyperplastic tissue**
- **Excision of pericoronal gingiva**
- **Surgical incision and drainage**
- **General anesthesia and intravenous (IV) sedation**, when used in conjunction with covered oral surgical procedures if Medically Necessary.

## Endodontic Services

- **Root Canal Therapy.** Coverage for root canal therapy includes a Treatment Plan, clinical procedures, postoperative radiographs, and follow-up care. If multiple endodontic treatments are necessary on the same tooth within a period of one year, the allowance will be made for only one procedure. Root canal therapy is limited to one initial treatment per tooth per lifetime and one retreatment per tooth per 12 months. Coverage is for permanent teeth only.
  - **Apicoectomy/periradicular services.** The Covered Dental Expense for apicoectomy / periradicular services includes reimbursement for the removal of granulation tissue at the apex of the tooth. No additional benefit is available for the removal of granulation tissue at the apex of the tooth if billed separately from the apicoectomy / periradicular service.
  - **Retrograde filling**
  - **Therapeutic pulpotomy (excluding final restoration).** Coverage is for primary teeth only.
  - **Gross pulpal debridement.** Not payable if performed in conjunction with root canal treatment or palliative emergency treatment.
  - **Hemisection**
- The following endodontic services are limited to a lifetime maximum of once per tooth/root:
- **Pulp capping, direct and indirect.** Coverage is for permanent teeth only.

## Periodontal Services

Coverage for periodontal surgical services includes Treatment Plan, local anesthesia, and routine postoperative care. Covered periodontal surgical services are:

- **Gingivectomy or gingivoplasty.** Limited to once per quadrant in any three years. When performed in conjunction with a crown build-up, post and core, or with a crown, the gingivectomy or gingivoplasty is considered part of that procedure and there will be no additional benefit.
- **Gingival flap procedure (includes root planing).** Limited to once per quadrant in any three years.
- **Crown lengthening.**
- **Osseous surgery, including flap entry with closure.** Limited to once per quadrant in any three years.
- **Bone replacement grafts** are a Covered Service for replacement of bone loss due to periodontal disease or defects only. No benefit is available for bone replacement grafts done in conjunction with extraction sites, ridge augmentation, or in preparation for the placement of implants. Limited to once per quadrant in any 3 years.
- **Soft tissue grafts.** The Covered Dental Expense for a soft tissue graft includes removal of tissue from a donor site and a single graft for one tooth or a single graft covering two adjacent teeth. No additional benefit is available when removal of the donor tissue is billed separately from the soft tissue graft or a single graft for two adjacent teeth is billed separately. Grafts are covered only to treat periodontal disease or defects. Limited to 2 per three years.
- **Biologic materials to aid in soft and osseous tissue regeneration.** Limited to once per tooth/site in any 3 years.
- **Full-mouth debridement** to enable comprehensive periodontal evaluation and diagnosis (removal of subgingival and/or supragingival plaque and calculus). Limited to once per 5 years.
- **Periodontal scaling and root planing.** Limited to twice per quadrant every 24 months.
- **Periodontal maintenance procedure.** Covered only when following active periodontal therapy. Limited to two procedures per Benefit Period, singly or in combination with routine prophylaxis.

## Prosthodontics (Crowns, Inlays, Onlays)

**Crowns, Inlays, Onlays.** Benefits for crowns, inlays, and onlays are limited to once per tooth in any five years, whether placement was under this Certificate or under any prior dental coverage, even if the original crown was stainless steel or “temporary”. Laboratory-fabricated restorations and crowns are covered only when the tooth cannot be restored with routine filling material.

- **Recementing of crowns/inlays/onlays.**
- **Crown buildups (includes pins).** Amalgam and/or composite restorations submitted in conjunction with crown buildups or post and core procedures will be considered as part of those procedures. Crown buildups performed in conjunction with post and any core procedures will be considered part of those procedures. Crown buildups on the same tooth as an amalgam or composite restoration done within the same Benefit Period will not be covered.
- **Post and core buildups.**
- **Crown/onlay repairs.**
- **Stainless steel crowns (for primary teeth only).** Limited to one in 12 months. Benefits are not provided for stainless steel crowns when used as a temporary crown.
- **Recement cast or prefabricated post and core.**

Covered adjunctive periodontal services are:

## Prosthodontics, Removable

The Covered Dental Expense for these services includes routine post-delivery care and all adjustments within the first 6 months after initial placement.

Covered Services include:

- **Removable complete (immediate or permanent), and partial dentures**, but only if the tooth/teeth being replaced were extracted after the Member's Effective Date. Limited to once in five years. Benefits are available for the replacement of complete or partial dentures, but only if the Prosthesis is five years old or older and cannot be made serviceable. Benefits are payable for either complete or immediate dentures, but not both.
- **Denture adjustments.**
- **Denture repairs.** Limited to once per denture in a five-year period.
- **Addition of tooth or clasp.**
- **Replace all teeth and acrylic on partial denture.** Limited to once per arch in any five year period.
- **Denture rebase and reline procedures.** Limited to once per Benefit Period for chairside reline and once in three years for laboratory rebase or reline.

Note: Adjustments, repairs or relines to dentures are not covered for a period of six months from initial placement if the denture(s) were paid for under this Certificate.

## Prosthodontics, Fixed

Fixed Prosthodontics are not a Covered Service when all molars are missing on one or both sides of an arch. Benefits are provided for the replacement of an existing bridge if it is five years old or older and cannot be made serviceable.

- **Fixed Bridges** are covered only when:

1. The bridge is replacing teeth that were extracted after the Member's Effective Date; and
2. The total units required to replace all missing teeth is six units or less in an arch (arch means maxilla or mandible); and
3. The bridge or bridges consist of no more than 6 units total in an arch. (Each abutment is a unit and each pontic is a unit in a bridge). The Covered Dental Expense for fixed bridgework that includes more than a total of 6 units is limited to the amount Plan would pay for a removable partial denture.

- **Recementing a bridge.**

- **Post and core.**

- **Core buildup.**

- **Bridge repair.**

**Note:** Benefits will not be provided for a pontic or an abutment if a fixed or removable partial, crown, or onlay was placed on the affected tooth/teeth in the last five years.

## Implants

Benefits for implants include:

- Implant supported Prosthetics limited to one per five years.

## Orthodontic Services

Orthodontia is limited to one course of treatment per Member per lifetime for dependent children under age 19 when initial bands are placed. Covered Services include examination records, tooth guidance, and repositioning (straightening) of the teeth, as listed below.

Orthodontic benefits are paid on a quarterly basis and payment is made over the course of treatment, up to the maximum lifetime orthodontic benefit shown in the "Schedule of

Benefits.” Orthodontic services are not subject to the Annual Maximum limit. **Refer to the “Schedule of Benefits” for Orthodontic Lifetime Maximum limit.**

For each eligible Member, the Plan pays the applicable payment rate shown in the “Schedule of Benefits” for the following orthodontic services:

- **Diagnostic orthodontic records.**
- **Limited Orthodontic Treatment.**
- **Interceptive Orthodontic Treatment**, primary or transitional dentition.
- **Comprehensive Orthodontic Treatment**, transitional or permanent dentition.
- **Minor treatment to control harmful habits.**
- **Orthodontic Retention.** Limited to a lifetime maximum of one Appliance per eligible Member.

## 12 EXCLUSIONS

This section indicates items which are excluded and are not considered Covered Services. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services. This list of exclusions is in no way a limitation upon, or a complete listing of, such items considered to be Non-Covered Services. We are the final authority for determining if services or treatments are Covered Services.

We do not provide benefits for:

1. Services not included as a covered procedure under **Covered Services**.
2. Procedures not yet recognized by the American Dental Association as indicated with a specific procedure code designation, or procedures which are considered experimental or investigative in nature or which are not widely accepted as proven and effective procedures within the organized dental community.
3. Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers’ compensation law or similar law, even if you do not claim those benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to any workers’ compensation law or similar law, We will provide the benefits of this Certificate for such conditions, subject to Our right to a lien or other recovery under applicable law.
4. Any services you actually received that were provided by a local, state or federal government agency except when payment under this Certificate is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free. Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
5. Any services for treatment of illness or injury that occurs as a result of any act of war, declared or undeclared.
6. Any services for treatment of injuries sustained or illnesses resulting from participation in a riot or civil disturbance, or while committing or attempting to commit an assault or felony (unless otherwise required by law).
7. Services for which you are not legally obligated to pay or services for which no charge is made to you in the absence of this or like coverage.

8. Services provided before or after the term of this coverage. Services received before your Effective Date under this Certificate or incurred after the termination date of this coverage except as specified elsewhere in this Certificate.
9. Professional services received from a person who lives in your home or who is related to you by blood, marriage or adoption.
10. Cosmetic dentistry: Any services performed for cosmetic purposes including, but not limited to, external bleaching, bleaching of non-vital discolored teeth, veneers, crowns on teeth not exhibiting pathology and facings on crowns on posterior teeth, unless they are for correction of functional disorders or as a result of an accidental injury occurring while you were covered for dental benefits under this Certificate.
11. Any amounts in excess of the dental benefit maximums stated in this Certificate. The Covered Dental Expense for all Covered Services includes the administration of any local anesthesia and the provision of infection control procedures as required by state and federal mandates. If billed separately, such charges will be denied.
12. Procedures requiring Appliances or restorations (other than those for replacement of structure lost due to dental decay) that are necessary to alter, restore or maintain occlusion, including treatment for:
  - Changing the vertical dimension
  - Replacing or stabilizing tooth structure lost by attrition, abrasion, erosion, or bruxism
  - Realignment of teeth
  - Gnathological recording
  - Occlusal equilibration (but not excluding such treatment needed to treat periodontal disease)
  - Periodontal splinting
13. Harmful Habit Appliances: fixed and removable Appliances to inhibit thumbsucking unless Orthodontic Services are included as Covered Services under this Certificate.
14. Replacement of an existing fixed or removable Prosthesis for which benefits were paid if replacement occurs within five years of the original placement, unless the Prosthesis is being used during the healing period for recently extracted anterior teeth.
15. Replacement of crowns, inlays, onlays and laboratory-fabricated restorations if replacement occurs within five years of the original placement.
16. Charges for the replacement of existing full or partial dentures or Appliances which have been lost or stolen.
17. Charges for any duplicate Prosthetic device or Appliance, or for a "spare" set of dentures or any other duplicate Appliance such as, but not limited to, removable orthodontic retainers.
18. Any prescribed drugs, pre-medication or analgesia including charges for nitrous oxide or any similar local anesthetic when the charge is made separately from a Covered Dental Expense.
19. Replacement of existing restorations for any purpose other than the treatment of pathology or decay.
20. Charges for the extraction of immature erupting third molars and nonpathologic, asymptomatic third molars is excluded.
21. Services for the treatment of malignancies and neoplasms and/or the removal of tumors, cysts, and foreign bodies, including histopathological exams (examination of cells by microscope).
22. Charges for tobacco counseling, oral hygiene instruction, dietary planning, or behavior management.

23. Any services related to diagnosis or treatment by any method of any condition related to the jaw joint (temporomandibular joint or TMJ) or associated musculature, nerves and other tissues, regardless of the reason(s) such services are necessary.
24. Treatment of congenital or developmental malformations including but not limited to cleft palate, maxillary and mandibular malformations, enamel hypoplasia, fluorosis, and anodontia.
25. Osseous grafts if the following procedures have been performed on the affected tooth or site on the same date of service or within the previous 12 months:
  - Apicoectomy
  - Retrograde filling
  - Root canal therapy
26. Personalization or characterization of dentures or teeth. Precision attachments and the replacement of part of a precision attachment.
27. Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
28. Maxillofacial Prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation.
29. Temporary and interim Prosthetics (temporary crowns, bridges, etc.). Temporary services are considered an integral part of the final services rather than a separate service, and are therefore not eligible for benefits.
30. Occlusal guards and occlusal analysis.
31. All hospital costs and any additional fees charged by the Dentist for hospital treatment.
32. Professional visits for house/extended care facility, hospital calls, office visits after regularly scheduled hours, and case presentations.
33. Teeth lost prior to coverage under this Certificate are not eligible for prosthetic replacement unless the prosthetic replacement replaces one or more eligible natural teeth lost during the term of this coverage.
34. Services or treatments that are not Medically Necessary.
35. If more than one Treatment Plan would be considered Medically Necessary for a Dental Condition, any amount exceeding the cost of the least expensive professionally acceptable Treatment Plan is not covered.
36. Charges for missed or cancelled appointments.
37. Transfer of Care: If a Member transfers from the care of one Dentist to that of another Dentist during the course of treatment, or if more than one Dentist renders services for one dental procedure, We shall be liable only for the amount it would have been liable for had one Dentist rendered the services.
38. Apically positioned flap.
39. Guided tissue regeneration.
40. Tissue conditioning.
41. Surgical placement of implants.
42. Implant maintenance.
43. Repair of an implant.
44. Removal of an implant.
45. **Orthodontic Care That Is Not Covered:**
  - a. Myofunctional therapy and related services. (Myofunctional therapy involves the use of muscle exercises as an adjunct to orthodontic mechanical correction of malocclusion.)

- b. Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate.
- c. Orthodontic services provided before or after the term of your coverage.
- d. Orthodontic treatment begun prior to your Effective Date or after the termination of your coverage.
- e. TMJ or Hormonal Imbalance Orthodontic Services. Orthodontic treatment related to temporomandibular joint disturbances (TMJ) and/or hormonal imbalance.
- f. Orthodontic re-treatment.

## 13 CLAIMS PAYMENT

### Payment of Benefits

You authorize Us to make payments directly to Providers for Covered Services. We also reserve the right to make payments directly to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by Us will discharge Our obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support order" as defined by ERISA or any applicable state law.

Once a Provider gives a Covered Service, We will not honor a request for Us to withhold payment of the claims submitted.

### Assignment

This Certificate is not assignable by the Group without the written consent of the Plan. The coverage and any benefits under this Certificate are not assignable by any Member without the written consent of the Plan, except as described in this Certificate.

### Notice of Claim

We are not liable under the Certificate, unless We receive written notice that Covered Services have been given to you. An expense is considered

incurred on the date the service or supply was given.

The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice can be submitted later than one year after the usual 90 day filing period ends. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the time frames specified in this provision or no benefits will be payable except as otherwise required by law.

### Claim Forms

Many Providers will file for you. If the forms are not available, either send a written request for claim forms to Us or contact customer service and ask for claim forms to be sent to you. The form will be sent to you within 15 days. If you do not receive the forms, written notice of services rendered may be submitted to Us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient
- Patient's relationship with the Subscriber
- Identification number

- Date, type and place of service
- Your signature and the Physician's signature

## Proof of Claim

Written proof of claim satisfactory to Us must be submitted to Us within 90 days after the date of the event for which claim is made. If proof of claim is not sent within the time required, the claim will not be reduced or denied if it was not possible to do send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to Us no later than one year following the 90 day period specified, unless you were legally incapacitated.

## Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's

Compensation or any other governmental program. Any Member who fails to cooperate will be responsible for any charge for services.

## Explanation of Benefits

After you receive dental care, you will often receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- total amounts charged for services/supplies received;
- the amount of the charges satisfied by your coverage;
- the amount for which you are responsible (if any);
- general information about your Appeals rights and for ERISA plans, information regarding the right to bring an action after the Appeals process.

# 14 GENERAL PROVISIONS

## Entire Contract

This Certificate, the Group Contract, the Group application, any Riders, Endorsements or Attachments, and the individual applications of the Subscriber and Dependents, if any, constitute the entire Contract between the Plan and the Group and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by the Group and any and all statements made to the Group by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Certificate, shall be used in defense to a claim under this Certificate.

## Form or Content of Certificate

No agent or employee of the Plan is authorized to change the form or content of this Certificate. Such changes can be made only through an endorsement authorized and signed by an officer of the Plan.

## Relationship of Parties (Plan - Network Dentists)

The relationship between the Plan and Network Dentists is an independent contractor relationship. Network Dentists are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Dentists.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Dentist or in any Network Dentist's facilities.

Your Network Dentist's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Dentists and Non-Network Dentists. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

## **Not Liable for Provider Acts or Omissions**

The Plan is not responsible for the actual care you receive from any person. This Certificate does not give anyone any claim, right, or cause of action against the Plan based on what a Provider of dental care, services or supplies, does or does not do.

## **Identification Card**

Your Identification Card lists the PPO network applicable to you. When you receive care from a Network or Non-Network Dentist, you must show your Identification Card. Possession of an Identification Card confers no right to services or other benefits under this Certificate. To be entitled to such services or benefits you must be an Member on whose behalf all applicable Premiums under this Certificate have been paid. If you receive services or other benefits to which you are not then entitled under the provisions of this Certificate you will be responsible for the actual cost of such services or benefits.

## **Circumstances Beyond the Control of the Plan**

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of the Plan, disability of a significant part of a Network Dentist's personnel or similar causes, or the rendering of dental care services provided under this Certificate is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Dentists shall render dental care services provided under this Certificate insofar as practical, and according to their best judgment; but the Plan and Network Dentists shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

## **Coordination of Benefits**

All benefits provided under this Certificate are subject to Coordination of Benefits.

Coordination of Benefits (COB) is the procedure used when a Member has dental care benefits under more than one dental care coverage. This Plan follows rules established by law to decide which plan pays first and how much the other plan must pay. The objective is to make sure the combined payments of all plans are no more than your actual bills.

When you or your family members are covered by another plan in addition to this one, this Plan will follow Coordination of Benefit rules to determine which plan is primary and which is secondary. You must submit all bills first to the primary plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary plan.

This Plan pays for dental care only when you follow its rules and procedures. If its rules conflict with those of another plan, it may be impossible

to receive benefits from both plans and you will be forced to choose which plan to use.

### **Plans That Do Not Coordinate**

This Plan will pay benefits without regard to benefits paid by the following kinds of coverage.

- Medicaid
- Group hospital indemnity plans which pay less than \$100 per day
- School accident coverage
- Some supplemental sickness and accident policies

### **How This Plan Pays When Primary**

- When this Plan is primary, it will pay the full benefits allowed by this Certificate as if you had no other coverage.

### **How This Plan Pays When Secondary**

- When this Plan is secondary, its payments will be based on the balance left after the primary plan has paid. It will pay no more than that balance. In no event will this coverage pay more than it would have paid if it had been primary.
- This Plan will pay only for dental care expenses that are Covered Services in this Certificate.
- This Plan will pay only if you have followed all of Our procedural requirements, including care obtained from or arranged by your Primary Care Physician, if applicable, etc.
- This Plan will pay no more than the "allowable expenses" for the dental care involved. If this Plan's allowable expense is lower than the primary plan's, then the primary plan's allowable expense will be used unless a Provider has agreed to accept this Plan's allowable expense as payment in full. The allowable expense may be less than the actual bill.

### **Which Plan Is Primary**

To decide which plan is primary, consider both the coordination provisions of the other plan and which member of your family is the patient. The primary plan will be determined by the first of the following which applies:

#### 1. Non-coordinating Plan

If you have another group coverage which does not coordinate benefits, that plan will always be primary.

#### 2. Insured / Employee

The plan which covers the patient as the insured is primary to the plan which covers the person as a Dependent; except, if that person is also a Medicare beneficiary and as a result of Medicare regulations, Medicare is:

- a. secondary to the plan covering the person as a Dependent; and
- b. primary to the plan covering the person as other than a Dependent (e.g., a retiree).

#### 3. Children (Parents Divorced or Separated)

If the court decree makes one parent responsible for dental care expenses, that parent's plan is primary.

If the court decree gives joint custody and does not mention dental care, this Plan follows the birthday rule.

If neither of these rules apply, the order will be determined in following order:

- a. The plan of the parent with custody;
- b. The plan of the spouse of the parent with custody;
- c. The plan of the parent not having custody; and
- d. The plan of the spouse of the parent not having custody.

#### 4. Children and the Birthday Rule

When your children's dental care expenses are involved, the "birthday rule" is followed. The plan of the parent with the first birthday in a calendar year is always primary for the children. If your birthday is in January and your spouse's birthday is in March, your plan will be primary for all of your children. If the parents' birthdays are the same, then whichever parent's plan has been in effect longer is primary.

However, if your spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's coverage is always primary), then the rules of that plan will be followed.

#### 5. Active Employment vs. Layoff or Retirement

The plan which covers the person as an active employee (or that employee's Dependent) is primary to another plan which covers that person as a laid off employee or a retiree (or that person's Dependent). If both plans do not include this same rule, then it will be ignored. This rule does not supersede rule 2, insured vs. Dependent.

#### 6. State or Federal Continuation Coverage

When the person's coverage is provided under a right of continuation under federal law (i.e. COBRA) or state law, any other plan covering that person will be primary to the plan covering the person under such continuation provision unless that other plan does not include this same rule.

#### 7. Length of Time Covered by the Plan

The plan which has covered the person for the longer period of time is primary to another plan.

#### 8. Other Situations

For all other situations not described above, the order of benefits will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.

**Right to receive and Release Needed Information** - Certain facts are needed to apply

COB rules. We have the right to decide which facts are needed. We may get needed facts from or give them to any other organization or person. We need not tell you, or get your consent to do this. Each person claiming benefits under this Plan must provide any facts needed to pay the claim.

**Facility of Payment** - A payment made under another plan may include an amount which should have been paid under this Plan. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan and We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

**Right of Recovery** - If the amount of the payments made by this Plan is more than should have been paid under this COB provision, We may recover the excess from one or more of:

- The persons it has paid or for whom it has paid;
- Another plan; or,
- The provider of service.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

**Coordination Disputes** – If you believe that We have not paid a claim properly, you should first attempt to resolve the problem by contacting Us. Follow the steps described in the "Complaint and Appeals Procedures" section of the Certificate.

If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call (614) 644-2673 or 1 (800) 686-1526.

## Worker's Compensation

The benefits under this Certificate are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

## Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payor, the benefits under this Certificate shall not duplicate any benefits to which Members are entitled or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.

## Subrogation and Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

### Subrogation

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have first priority for the full amount of benefits We have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.

- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Certificate.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs you incur without Our prior written consent. We further agree that the "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

### Reimbursement

If you obtain a Recovery and We have not been repaid for the benefits We paid on your behalf, We shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction

for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:
  1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
  2. You fail to cooperate.
- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the Providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and We would not have any obligation to pay the Provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

### Your Duties

- You must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with Us in the investigation, settlement and protection of Our rights.

- You must not do anything to prejudice Our rights.
- You must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify Us if you retain an attorney or if a lawsuit is filed on your behalf.

### Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

### Relationship of Parties (Group-Member-Plan)

Neither the Group nor any Member is the agent or representative of the Plan.

The Group is fiduciary agent of the Member. The Plan's notice to the Group will constitute effective notice to the Member. It is the Group's duty to notify the Plan of eligibility data in a timely manner. The Plan is not responsible for payment of Covered Services of Members if the Group fails to provide the Plan with timely notification of Member enrollments or terminations.

## Conformity with Law

Any provision of this Certificate which is in conflict with the laws of the state in which the Group Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

## Modifications

This Certificate allows the Group to make the Plan coverage available to eligible Members. However, this Certificate shall be subject to amendment, modification, and termination in accordance with any of its provisions, the Group Contract, or by mutual agreement between the Plan and the Group without the permission or involvement of any Member. Changes will not be effective until 30 days after We provide written notice to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting the Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms, conditions, and provisions in this Certificate.

## Clerical Error

Clerical error, whether of the Group or the Plan, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

## Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Grievance and Appeal Procedures before filing a lawsuit or other legal action of any kind against Us.

## Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Certificate with which a Member shall comply.

## Waiver

No agent or other person, except an authorized officer of the Plan, has able to disregard any conditions or restrictions contained in this Certificate, to extend the amount of time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

## Plan's Sole Discretion

The Plan may, in its sole discretion, cover services and supplies not specifically covered by the Certificate. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies, which would otherwise be required for the care and treatment of a Member.

## Reservation of Discretionary Authority

**The following provision only applies where the interpretation of this Certificate is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.**

The Plan, or anyone acting on Our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, We, or anyone acting on Our behalf, has complete discretion to determine the administration of Your benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are covered. However, a Member may utilize all applicable Grievance and Appeals Procedures.

The Plan, or anyone acting on Our behalf, shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation and administration of the Certificate. This includes, without limitation, the power to construe the Group Contract, to determine all questions arising under the Certificate, to resolve Member Grievances and Appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation and administration of the provisions of this Certificate. However, these

powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Group Contract the Certificate, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

## Anthem Blue Cross and Blue Shield Note

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Certificate constitutes a contract solely between the Group and Community Insurance Company dba Anthem Blue Cross and Blue Shield (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Ohio. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

## 15 GRIEVANCE AND APPEAL PROCEDURES

This section explains and offers instructions on what to do if a Member disagrees with a denial or modification of a dental claim, or is dissatisfied with the dental treatment or a service rendered and wishes to file a Grievance or Appeal of a decision previously made.

### Grievances

If a Member has a Grievance about any aspect of Our service, such as the processing of a dental claim, dental treatment or services rendered the Member should contact Our customer service

department. We will acknowledge receipt of the Grievance and provide a resolution within the state's specified Grievance resolution time frames. A Member may file a verbal Grievance through Our toll-free number or submit a written Grievance to the address listed below. If after working with Us the Member is not satisfied with the resolution of their Grievance, the Member may file an Appeal as explained in the Appeals section below:

Anthem Blue Cross and Blue Shield  
Grievance Department

P.O. Box 9277  
 Oxnard, CA 93031-9277  
 1-800-627-0004

## Appeals

A Member may file an Appeal either verbally or in writing. We will acknowledge receipt of your Appeal of a Grievance and provide a resolution within the state's specified Appeal resolution time frames. An Appeal may be filed with or without having first submitted a formal Grievance. An Appeal may be filed for any dental claim that has been denied in whole or in part or to request a reconsideration for any adverse Grievance decision. In the Appeal, please state plainly the reason(s) why the treatment or service should not have been denied or why the adverse Grievance decision should be reversed. All clinical Appeals will be reviewed by an individual not previously involved in the original decision. Any documents or information not originally submitted should be included that may have a bearing on Our decision.

Please send written Appeals to the following address or contact Us at the toll-free phone number listed below:

Anthem Blue Cross and Blue Shield  
 Appeals Department  
 P.O. Box 9274  
 Oxnard, CA 93031-9274  
 1-800-627-0004

The Member may designate a representative (e.g., your healthcare provider or anyone else of your choosing) to file a Grievance or Appeal on your behalf. We must receive a written designation before working with your representative.

The Grievance and Appeals process is governed by laws and regulations, and may be modified from time to time by Us as those laws may require.

Both TTY/TDD services for the hearing and speech impaired and language translation assistance are available upon request to assist the Member in filing a Grievance or Appeal.

## Expedited Appeal and/or Expedited Independent External Review

For pre-treatment denials based on utilization review, an expedited Appeal and/or expedited independent external review, may be available to the Member based on state specific requirements.

In the case of a benefit denial based on a retrospective review, an independent external review Appeal may also be available based on state specific requirements.

## Grievances and Appeals by Members of ERISA Plans

If you are covered under a Group plan which is subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), you must file a Grievance prior to bringing a civil action under 29 U.S.C. 1132 §502(a). An Appeal of a Grievance decision is a voluntary level of review and need not be exhausted prior to filing suit. Any statutes of limitations or other defenses based upon timeliness will be tolled while an Appeal is pending. You will be notified of your right to file a voluntary Appeal if Our response to your Grievance is adverse. Upon your request, We will also provide you with detailed information concerning an Appeal, including how panelists are selected.



ANTHDB-01

Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company  
An independent licensee of the Blue Cross and Blue Shield Association.  
® Registered marks Blue Cross and Blue Shield Association.



*Underwritten by Community Insurance Company*

# Notice of Privacy Practices

# HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

## Your Protected Health Information

We may collect, use, and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

**For Payment:** We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

**For Health Care Operations:** We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes, or traumatic injury.

**For Treatment Activities:** We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so

that the provider may treat you.

**To You:** We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

**To Others:** You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present, and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

**As Allowed or Required by Law:** We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety.

It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

If you are enrolled with us through an employer sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

**Authorization:** We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

## Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.

- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. They can give you the address to send the request. They can also give you any forms we have that may help you with this process.

## How we protect information

We are dedicated to protecting your PHI. We set up a number of policies and practices to help make sure your PHI is kept secure. We keep your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include offices that are kept secure, computers that need passwords, and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong, out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

### **Potential Impact of Other Applicable Laws**

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

### **Complaints**

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

### **Contact Information**

Please call Customer Service at the phone number printed on your ID card. They can help you apply

your rights, file a complaint, or talk with you about privacy issues.

### **Copies and Changes**

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

## STATE NOTICE OF PRIVACY PRACTICES

As we told you in our HIPAA notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

### Your Personal Information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter. PI could also be used to make judgments about your health, finances, character, habits, hobbies, reputation, career, and credit.

We may collect PI about you from other persons or entities such as doctors, hospitals, or other carriers.

We may share PI with persons or entities outside of our company without your OK in some cases.

If we take part in an activity that would require us to give you a chance to opt-out, we will contact you. We will tell you how you can let

us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

We take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo

adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This Notice is provided by the following companies:



Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In most of Missouri: RightCHOICE<sup>®</sup> Managed Care, Inc. (RIT), Healthy Alliance<sup>®</sup> Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross and Blue Shield of Wisconsin ("BCBSWi") underwrites or administers the PPO and indemnity policies; CompCare Health Services Insurance Corporation ("CompCare") underwrites or administers the HMO policies; and CompCare and BCBSWi collectively underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. <sup>®</sup> ANTHEM is a registered trademark. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.