DENTAL BENEFIT BOOKLET

DIOCESE OF FORT WAYNE – SOUTH BEND INC.
PPO Dental Plan
Effective 1/1/ 2016

Administered By

Anthem BlueCross BlueShield

BENEFIT BOOKLET

This Benefit Booklet has been prepared by the Claims Administrator, on behalf of the Employer, to help explain Your dental benefits. This document replaces and supersedes any Benefit Booklet or summary that You have received previously.

Please refer to this Benefit Booklet whenever You require dental services. It describes how to access dental care, what health services are covered by the Plan, and what portion of the dental care costs You will be required to pay.

This Benefit Booklet should be read and re-read in its entirety. Since many of the provisions of this Benefit Booklet are interrelated, You should read the entire Benefit Booklet to get a full understanding of Your dental benefits.

Many words used in the Benefit Booklet 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.

This Dental Benefit Booklet also contains Exclusions, so please be sure to read this Dental Benefit Booklet carefully.

Si usted necesita ayuda en español para entender este documento, puede solicitarla gratuitamente llamando a Servicios al Cliente al número que se encuentra en su tarjeta de identificación.

If You need assistance in Spanish to understand this document, You may request it for free by calling customer service at the number on Your Identification Card.

Administered by
Anthem Insurance Companies, Inc.

Important: This is <u>not</u> an insured benefit plan. The benefits described in this Benefit Booklet or any rider or amendments hereto are funded by the Employer who is responsible for their payment. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the amount of benefits the Plan will pay when You receive Covered Services from a Provider. Please refer to the **Covered Services** section for a more complete explanation of the specific dental services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of this Benefit Booklet including any attachments or riders.

Benefit Period Calendar Year

Dependent Child Age Limit To the end of the month in which the child attains age 26.

Orthodontic Age Limit To the Dependent child's 19th birthday.

Any Other Dental Product –

Deductible	**Network**	**Non-Network**
Single	$50	

Annual Maximum	**Network**	**Non-Network**
Single	$1,000	

Orthodontic Lifetime Maximum (does not apply to the Annual Maximum)	$500

COVERED SERVICES	COPAYMENTS/MAXIMUMS	
	Network	**Non-Network**
Class I Diagnostic and Preventive Services (Not subject to the Deductible)	Covered in Full up to Maximum Allowable Amount	Covered in Full up to Maximum Allowable Amount (The Member is responsible for any balance due after the Plan payment)
<u>The following services are subject to the Deductible:</u>		
Class II General (Adjunctive) Services	50% Coinsurance	
Class II Restorative Services	50% Coinsurance	
Class II Endodontic Services	50% Coinsurance	
Class II Oral Surgery Services	50% Coinsurance	
Class II Periodontal Services	50% Coinsurance	
Class III Prosthodontic Services	25% Coinsurance	
Class IV Orthodontic Services (Not subject to the Deductible)	50% Coinsurance	

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.

Administrative Services Agreement - The agreement between the Claims Administrator and the Employer regarding the administration of certain elements of the health care benefits of the Employer's Group Health Plan.

Alternate Recipient - Any child of a Subscriber who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment under the Plan with regard to such Subscriber.

Annual Maximum - The maximum dollar amount payable for Covered Services for each Member during a Benefit Period. The Benefit Period is listed in the Schedule of Benefits. The amounts applied to the Annual Maximum are based on the Maximum Allowable Amount for Covered Services. The annual benefit limit includes both Network and Non-Network services, but does not include the Member's Deductible or Copayment amounts. 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 Maximums 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 Booklet - This summary of the terms of Your health benefits.

Benefit Period - The period of time that benefits for Covered Services are payable under the Plan. The Benefit Period is listed in the Schedule of Benefits. If Your coverage ends earlier, the Benefit Period ends at the same time.

Claims Administrator - An organization or entity that the Employer contracts with to provide administrative and claims payment services under the Plan. The Claims Administrator is Anthem Insurance Companies, Inc. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance - A specific percentage of the Maximum Allowable Amount for Covered Services that is indicated in the Schedule of Benefits, which You must pay. Coinsurance normally applies to the Deductible that You are required to pay. See the Schedule of Benefits for any exceptions.

Coordination of Benefits - A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

Covered Charges -- Charges for Covered Services to the extent that, in the Plan's judgment, such charges are not excessive. This judgment will be based on professional dental opinion or upon the Maximum Allowable Amount for similar Providers who perform like Covered Services.

Covered Dependent - Any Dependent in a Subscriber's family who meets all the requirements of the Eligibility section of this Benefit Booklet, has enrolled in the Plan, and is subject to Administrative Service Fee requirements set forth by the Plan.

Covered Services - Services, supplies, or treatment as described in the Benefit Booklet, which are performed, prescribed, directed, or authorized by a Provider. 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 Benefit Booklet is in force;
- Within the Maximum Allowable Amount;
- Not specifically excluded or limited by the Benefit Booklet; and
- Specifically included as a benefit within the Benefit Booklet.

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 specified dollar amount of Covered Charges, stated in the Schedule of Benefits, which You must incur before the Plan begins to pay benefits, which are subject to the Dental Deductible.

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

Dental Plan Document - This Benefit Booklet in conjunction with the Dental Plan Document, the application, if any, any amendment or rider, Your Identification Card and Your application for enrollment constitutes the entire Plan. If there is any conflict between either this Benefit booklet or the Dental Plan Document and any amendment or rider, the amendment or rider shall control. If there is any conflict between this Benefit Booklet and the Dental Plan Document, the Dental Plan Document shall control.

Dependent - A person of the Subscriber's family who is eligible for coverage under the Plan.

Effective Date - The date Your coverage begins under the Plan. A Dependent's coverage under the Plan begins on the Effective Date of the sponsoring Subscriber. No benefits are payable for services and supplies received before Your Effective Date or after Your termination date.

Employee - A person who is engaged in active employment with the Employer and is eligible for Plan coverage under the employment regulations of the Employer. The Employee is also called the Subscriber.

Eligible Person - A person who satisfies the Employer's eligibility requirements and is entitled to apply to be a Subscriber.

Employer – The legal entity contracting with the Claims Administrator for administration of group health care benefits.

Enrollment Date - The first day of coverage under the Plan 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.

Family Coverage – Coverage provided by the Employer for the Subscriber and eligible Dependents.

Fee(s) - The periodic charges, which are required to be paid by You and/or the Employer to maintain benefits under the Plan.

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 Employer and the Administrator.

Identification Card - A card issued by the Claims Administrator, on behalf of the Employer, that bears the Member's name, identifies the membership by number, and may contain information about Your benefits under the Plan. It is important to carry this card with You.

Maximum Allowed Amount - The maximum amount of reimbursement for Covered Services under the Pan, as outlined under the section "How Maximum Allowed Amount Is Determined" section of this Benefit Booklet.

Medically Necessary - 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 Employer and for whom Fee payment has been made. Members are sometimes called "You" or "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 the Claims Administrator or with another organization which has an agreement with the Claims Administrator, 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 the Claims Administrator at the time services are rendered.

New Hire - A person who is not employed by the Employer on the original Effective Date of the Plan.

Member - The Subscriber and each Dependent, as defined in this Benefit booklet, while such person is covered by this Plan.

Plan – The group health benefit Plan provided by the Employer and explained in this Benefit Booklet.

Plan Administrator - The person or entity named by the Plan Sponsor to manage the Plan and answer questions about Plan details. ***The Plan Administrator is not the Claims Administrator.***

Plan Sponsor - The legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination.

Pretreatment Estimate - A Pretreatment Estimate identifies the Plan's estimated financial liability before treatment is started. This estimate may include some or all of the following information:

- Patient's eligibility
- Covered Services
- Benefit amounts payable
- Deductible amounts, if applicable
- Copayments
- Maximum benefit limitations

Such estimates are subject to the terms of the Member's coverage.

Prior Plan – The plan sponsored by the Employer which was replaced by the benefits under this Plan within 60 days. You are considered covered under the Prior Plan if You: (1) were covered under the Prior Plan on the date that plan terminated; (2) properly enrolled for coverage within 31 days of this Plan's effective date; and (3) had coverage terminate solely due to the Prior Plan's termination.

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**.** Providers that deliver Covered Services are described throughout this Benefit Booklet. If You have a question if a Provider is covered, please call the number on the back of Your ID Card.

QMCSO, or MCSO – Qualified Medical Child Support Order or Medical Child Support Order - A QMCSO creates or recognizes the right of a child who is recognized under the order as having a right to be enrolled under the dental benefit plan to receive benefits for which the Employee is entitled under the plan; and includes the name and last known address of the Employee and each such child, a reasonable description of the type of coverage to be provided by the plan, the period for which coverage must be provided and each plan to which the order applies.

An MCSO is any court judgment, decree or order (including a court's approval of a domestic relations settlement agreement) that:

- provides for child support payment related to dental benefits with respect to the child of a group dental plan Member or requires dental benefit coverage of such child in such plan, and is ordered under state domestic relations law; or
- enforces a state law relating to medical child support payment with respect to a group dental plan.

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 Benefit Booklet.

Service Area - The geographical area within which Covered Services under the Plan are available.

Single Coverage – Coverage for the Subscriber only.

Spouse - For the purpose of this Plan, a Spouse is defined as shown in the Eligibility section of this Benefit Booklet.

Subscriber - An eligible employee or retired employee or member of the Employer enrolled under the Plan, whose benefits are in effect and whose name appears on the Identification Card issued by the Claims Administrator, on behalf of the Employer.

Treatment Plan - A detailed description, submitted by the Provider, outlining the proposed services and fees including any appropriate radiographs and diagnostic information when a Pretreatment Estimate is requested.

ELIGIBILITY, ENROLLMENT AND TERMINATION

Eligibility for Benefit

(1) Employee Eligibility – Each Employee is eligible to enroll provided such Employee meets all of the following Requirements:

a. is in an eligible class as shown below:

(i.) all active, full-time Employees defined as follows:

Lay Employees (Non Teaching) who consistently maintain active employment of at least 30 hours per week;

Lay Employee (Elementary School Teacher) – a person who is contracted to teach 30 or more hours per week for a consecutive period equivalent to at least one full semester during the school year; or

Lay Employee (High School Teacher) – a person who is contracted to teach an average of five classroom periods of recitation and assumes daily supervisory assignments for a consecutive period equivalent to at least one full semester during the school year.

b. has completed a service requirement referred to as a Waiting Period:

(i.) the first day of the month following full-time employment;

c. has completed an enrollment application.

Failure of the Employee to enroll in the 30 days following the end of the Waiting Period will result in the Employee having to wait until Open Enrollment (January 1) to make application for coverage unless the Employee qualifies for Special Enrollment.

(2) Dependent Eligibility – Each Employee that is enrolled can enroll Dependents under the Plan on the later of the following:

a. for initially eligible Dependents, the date of the Employee is eligible to enroll; or

b. for newly acquired Dependents, the date the Dependent is first acquired by the Employee if the Employee is enrolled on that date.

Failure to enroll initially eligible Dependents in the 30 days following the end of the Employee Waiting Period will result in the Dependent having to wait until Open Enrollment (January 1) to make application for coverage unless the Employee qualifies for Special Enrollment.

The event of acquiring a new Dependent means marriage, birth, adoption, placement for adoption or satisfying any other definitions of Dependency as described in this Plan.

The election to enroll a newly acquired Dependent can occur at any time not more than 30 days following the event of acquiring the Dependent. If the Employee has dependent coverage under this Plan and such Employee or spouse of the Employee gives birth, the newborn Dependent shall be enrolled in the Plan automatically as of the date of birth. Any other newly acquired Dependent must be enrolled in accordance with the terms of the Plan. Failure to enroll a newly acquired Dependent in the 30 days following the acquisition event will result in the Dependent having to wait until Open Enrollment (January 1) to make application for coverage unless the Dependent qualifies for Special Enrollment.

No person is eligible for coverage as an Employee and as a Dependent. If both parents of a child are covered Employees under the Plan, the child may be covered as a Dependent of only one parent.

(3) Dependents eligible to participate include:

a. Coverage will be extended only to opposite sex Spouse of the Employee. For information on spousal eligibility please contact the Employer; and

b. a natural child, a step child, a legally adopted child, a child placed for adoption, a child who has been placed under the legal guardianship of the Employee or a child for whom the Employee has financial responsibility for medical Expense as the result of a legal decree. To be eligible, a child also must meet all of the following conditions:

    (i) dependent children until at the end of the month they attain age 26

NOTE: Under any circumstance, a Dependent child covered under the predecessor plan on the day prior to the effective date of this Plan shall be covered by this Plan as long as such child continues to satisfy criteria (i) of this Section (3) b. The limiting age of 26 does not apply to an enrolled child who is mentally or physically handicapped at or prior to the time the child reaches the limiting age. Upon attaining the limiting age, the child must also be incapable of self-sustaining employment and chiefly dependent upon the Employee for support and maintenance. Proof of incapacity must be furnished to the Employer; additional proof may be requested from time to time.

ADOPTED CHILDREN: The Plan allows coverage of a child who has been adopted or placed for adoption. Placement for adoption means the assumption and retention by a Plan Participant of a legal obligation for total or partial support of such child in anticipation of such adoption.

Qualified Medical Child Support Order

(1) A Qualified Medical Child Support Order (QMCSO) is a court judgment or decree that requires the Plan to offer coverage to the child of a Participant, referred to as an alternate recipient.

(2) The medical child support order must meet four requirements to be deemed as qualified:

a. disclose the name and last known mailing address of the Participant and each alternate recipient;
b. reasonably describe the type of benefits or coverage to be provided by the Plan;
c. define the period of time to which the order applies; and
d. identify each Plan to which the order applies.

(3) The QMCSO cannot require the Plan to provide benefits not included under the Plan.

(4) Coverage of an alternate recipient is subject to all provisions of the Plan including, but not limited to, timely payment of required contributions, enrollment procedures and limitations of coverage.

(5) The Plan Administrator has established procedures for determining if a court judgment or decree is a QMCSO. A Participant can obtain a copy of these procedures without cost upon written request to the Plan Administrator.

Application For Participation

(1) Each Employee must apply for Plan participation on such forms or electronic format as the Employer shall provide and shall agree to the terms of the Plan. The Employer shall determine Participant eligibility based upon information supplied.

(2) The enrollment application shall include a statement which, upon signature or acceptance by the Employee, authorizes the Employer to make payroll withholding of any required contribution by the Employee for the cost of benefits. Such authorization is part of the application procedure.

(3) If a declination to enroll occurs due to other coverage of an Employee or Dependent, the Employee must state in writing that the reason for declination is due to other coverage. Failure to make the written statement will void the right to Special Enrollment at a future date.

(4) The Participant is solely responsible for the accuracy of information and to notify the Plan Administrator of any change in status that may have a material effect on eligibility or otherwise affect the capability of the Plan Administrator to fulfill the obligations of the Plan.

Effective Date of Coverage

(1) If completion of the enrollment application occurs prior to or during the 30 days immediately following the scheduled effective date, coverage begins on the scheduled effective date.

(2) The scheduled effective date is the first day of the month coincident with or next following the end of the service Waiting Period. The service Waiting Period begins on the first day of Actively At Work, full-time employment.

(3) If an Employee is not Actively at Work on the scheduled effective date except for health related causes and the effective date is a regularly scheduled work day, neither Employee nor Dependent coverage begins until the day the Employee returns to active, full-time employment.

(4) If the scheduled effective date falls on a non-work or vacation day, coverage begins on the scheduled effective date if the Employee was Actively at Work on the last preceding regularly scheduled work day or, if absent from work, such absence was due to health related causes. Otherwise, neither Employee nor Dependent coverage begins until the day the Employee returns to active, full-time employment.

(5) Upon completion of application requirements, the effective date of coverage for Dependents is described as follows:

a. for initially eligible Dependents, the date the Employee is effective;

b. for newly acquired Dependents, the date a Dependent is first acquired by the Employee if the Employee is covered on that date; or

(6) A terminated Employee, whose coverage has terminated, may reapply for coverage within twelve (12) months following such termination of employment without fulfilling the Waiting Period requirement.

Special Enrollment

(1) A Special Enrollment right exists for eligible Employees and Dependents who previously declined coverage under this Plan due to having other health coverage and subsequently loses such other coverage. To qualify for Special Enrollment, the Employee must:

a. state in writing at the time of initial eligibility that declination of coverage under this Plan was due to having other coverage;

b. make the request for Special Enrollment; and

c. complete any required Enrollment Forms under this Plan not more than 30 days following the loss of other coverage.

(2) A person who enrolls under the provisions for Special Enrollment is not subject to the Waiting Period.

(3) The Special Enrollment right requires:

a. If the other coverage is COBRA continuation, the Special Enrollment request is available only after exhausting the maximum eligible duration of COBRA coverage.

b. If the other coverage is not COBRA continuation, the Special Enrollment request is available only after losing eligibility for the other coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or after cessation of Employer contributions for the other coverage.

(4) The Special Enrollment right does not apply if the Participant loses other coverage as a result of failure to pay premiums or for cause, such as (but not limited to) making a fraudulent claim.

(5) The effective date of coverage under this Plan shall be:

a. if enrollment in this Plan occurs not more than 30 days following the loss of other coverage, the date of losing other coverage; or

b. if enrollment in this Plan occurs more than 30 days following the loss of other coverage, the date of enrollment in this Plan.

Dependent Special Enrollment

(1) A Dependent Special Enrollment right exists for Eligible Employees and Dependents upon the acquisition of a new Dependent through marriage, birth of a child, adoption of a child, or placement of a child for adoption. To qualify for the Dependent Special Enrollment right, the Employee must request the Dependent Special Enrollment and complete any required Enrollment Forms under this Plan not more than 30 days following the acquisition of a new Dependent.

(2) Eligible Employees and Spouses who previously declined coverage may also enroll under the Dependent Special Enrollment right, provided they are otherwise eligible.

(3) A person who enrolls under the provisions for Dependent Special Enrollment is not subject to the Waiting Period.

(4) The effective date of coverage under this Plan in the case of Dependent Special Enrollment shall be:

a. if enrollment in this Plan occurs not more than 30 days following the loss of other coverage, the date of losing other coverage; or

b. For a newborn or adopted child, coverage is retroactive to the date of birth or date of adoption.

Medicaid and CHIP Special Enrollment/Special Enrollees

Eligible Employees and Dependents may also enroll under two additional circumstances:

- the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Employee or Dependent becomes eligible for a subsidy (state premium assistance program).

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

Termination of Coverage

Coverage of an Employee or Dependent ends when the first of the following events takes place.

(1) the date the Plan ends;

(2) the date the Participant is no longer in an eligible class or satisfies the definitions of eligibility as stated in the Eligibility Provisions of this Plan;

(3) the date the Plan is changed to end benefits for the class to which the Participant belongs;

(4) the end of the period for which the Participant no longer satisfies the Contributory cost requirement established by the Employer; or

(5) the end of the month in which employment is terminated; or

(6) the day of the Plan Month in which the Participant requests such coverage be terminated.

The end of coverage will not affect any claim made for benefit while a Participant.

Family and Medical Leave (FMLA)

An employee may continue membership in the Plan as provided by the Family and Medical Leave Act. An employee who has been employed at least one year, within the previous 12 months is eligible to choose to continue coverage for up to 12 weeks of unpaid leave for the following reasons:

- The birth of the employee's child.
- The placement of a child with the employee for the purpose of adoption or foster care.
- To care for a seriously ill spouse, child or parent.
- A serious health condition rendering the employee unable to perform his or her job.

If the employee chooses to continue coverage during the leave, the employee will be given the same health care benefits that would have been provided if the employee were working, with the same premium contribution ratio. If the employee's premium for continued membership in the Plan is more than 30 days late, the Employer will send written notice to the employee. It will tell the employee that his or her membership will be terminated and what the date of the termination will be if payment is not received by that date. This notice will be mailed at least 15 days before the termination date.

If membership in the Plan is discontinued for non-payment of premium, the employee's coverage will be restored to the same level of benefits as those the employee would have had if the leave had not been taken and the premium payment(s) had not been missed. This includes coverage for eligible dependents. The employee will not be required to meet any qualification requirements imposed by the Plan when he or she returns to work. This includes: new or additional waiting periods; waiting for an open enrollment period; or passing a medical exam to reinstate coverage. Please contact Your Human Resources Department for state specific Family and Medical Leave Act information.

Military Leave Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA)

Under USERRA, if the Employee (or his or her Dependents) is covered under this Plan, and if the Employee becomes absent from employment by reason of military leave, the Employee (or his or her Dependents) may have the right to elect to continue health coverage under the plan. In order to be eligible for coverage during the period that the Employee is gone on military leave, the Employee must give reasonable notice to the Employer of his or her military leave and the Employee will be entitled to COBRA-like rights with respect to his or her medical benefits in that the Employee and his or her Dependents can elect to continue coverage under the plan for a

period of 24 months from the date the military leave commences or, if sooner, the period ending on the day after the deadline for the Employee to apply for or return to work with the Employer. During military leave the Employee is required to pay the Employer for the entire cost of such coverage, including any elected Dependents' coverage. However, if the Employee's absence is less than 31 days, the employer must continue to pay its portion of the Premiums and the Employee is only required to pay his or her share of the Premiums without the COBRA-type 2% administrative surcharge.

Also, when the Employee returns to work, if the Employee meets the requirements specified below, USERRA states that the Employer must waive any exclusions and waiting periods, even if the Employee did not elect COBRA-like continuation. These requirements are (i) the Employee gave reasonable notice to his or her Employer of military leave, (ii) the military leave cannot exceed a prescribed period (which is generally five (5) years, except in unusual or extraordinary circumstances) and the Employee must have received no less than an honorable discharge (or, in the case of an officer, not been sentenced to a correctional institution), and (iii) the Employee must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon the period that he or she was gone). The Employee may also have to provide documentation to the Employer upon reemployment that would confirm eligibility. This protection applies to the Employee upon reemployment, as well as to any Dependent who has become covered under the Plan by reason of the Employee's reinstatement of coverage.

HOW TO OBTAIN COVERED SERVICES

Network Services and Benefits

If a Network Provider renders Your care, benefits will be provided at the Network level. Refer to the Schedule of Benefits. No benefits will be provided for care that is not a Covered Service even if performed by a Network Provider.

Although the Claims Administrator may inform You that a service You received is not a Covered Service under the Plan, You may appeal this decision. See the Member Grievances section of this Benefit Booklet.

Network Providers are Professional Providers and other facility Providers who contract with the Claims Administrator to perform services for You. You will not be required to file any claims for services You obtain directly from Network Providers.

Non-Network Services and Benefits

Services, which are not obtained from a Network Provider, will be considered a Non-Network Service. In addition, certain services may not be covered unless obtained from a Network Provider, and/or may result in higher cost-share amounts. See Your Schedule of Benefits. You will be required to file claims for services You obtain directly from a Non-Network Provider.

Relationship of Parties **(Plan - Network Providers)**

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

The Claims Administrator or the Subcontractor 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 Provider or in any Network Provider's facilities.

Your Network Provider'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 and Non-Network Providers. If You have questions regarding such incentives or risk sharing relationships, please contact the Claims Administrator or Your Provider.

Not Liable for Provider Acts or Omissions

The Claims Administrator and/or the Employer are not responsible for the actual care You receive from any person. This Benefit Booklet does not give anyone any claim, right, or cause of action against the Claims Administrator and/or the Employer based on what a Provider of dental care, services or supplies, does or does not do.

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 exclusions listed in the Exclusions section.

Benefits are limited to Covered Services stated in this Benefit Booklet for dental disease, prevention, diagnosis, and treatment. Coverage is subject to all the terms and limitations stated in this Benefit Booklet, including benefit maximums.

The Maximum Allowable Amount 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.

Class I - Preventive Diagnostic and Preventive Services (No Deductible)

Diagnostic and preventive services are services that are used to avert dental disease or to determine the nature or cause of a dental disease. Covered Services include examinations, oral evaluations, x-rays, teeth cleaning and scaling, fluoride treatments, sealants, and selected space maintainers, as listed below.

Oral Evaluation

Limited to two per Benefit Period in any combination of the following types of evaluations: periodic, limited (emergency), comprehensive, detailed, and extensive.

Dental Radiographs (X-rays)

- **Bitewing** radiographs (up to four), limited to once per Benefit Period.
- **Complete series** (panoramic film or full-mouth radiographs), limited to once every three 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 and bitewing radiographs will be considered a complete series.

Note: Benefits are not provided for periapical x-rays when performed on the same date as a complete series or a panoramic film.

Radiographs may be allowed more frequently if requested by the Claims Administrator, on behalf of the Employer, for diagnostic evaluation. The Claims Administrator reserves the right to request radiographs and/or diagnostic data from the Provider of service.

Cleaning, Scaling, and Polishing the Teeth (Prophylaxis)

Limited to two per Benefit Period, which can vary in degree of difficulty (see "Periodontal Services" for limitations on periodontal scaling and periodontal maintenance procedures).

Space Maintainers

When used to maintain the space for prematurely lost teeth and only when necessary to prevent future orthodontic care. This benefit is provided only once per lifetime and is not available after the Member's 12th birthday. Space maintainers will be recemented only once per lifetime.

Other Diagnostic and Preventive Services

Dependent children under the age of 16 are eligible to receive benefits for the following diagnostic and preventive services (benefits are not available after the Dependent's sixteenth birthday):

- **Fluoride treatments** (topical application), limited to two per Benefit Period.
- **Sealants,** but only to the unrestored occlusal surface of permanent, posterior (molar) teeth, limited to once per Benefit Period and a lifetime maximum of two applications per tooth.

Class II – Basic General (Adjunctive), Restorative; Specialty Services (Endodontic, Oral Surgery and Periodontal) Services

Covered Services include limited emergency care, office visits, consultations, and anesthesia services, as listed below.

- **Palliative (Emergency) Treatment for Dental Pain,** limited to two treatments per Benefit Period (not covered when performed in conjunction with other dental treatment).
- **Consultations,** limited to a lifetime maximum of once per Provider (not covered when performed in conjunction with examinations).
- **General anesthesia,** when administered by a qualified, licensed professional; surgical procedures only.
- **Intravenous sedation,** when administered by a qualified, licensed professional; surgical procedures only.
- **Office visit for observation,** limited to two visits per Benefit Period (not covered when associated with other services or procedures).

Restorative Services

The process of replacing, by artificial means, a part of a tooth that has been damaged by disease (e.g., cavities). Covered Services include "filling" teeth and preparing teeth for fillings, as listed below. For services to replace a missing tooth or restore a tooth using a crown, see **Prosthodontic Services.** Restorative services must not be solely for replacement of existing restorations.

The following are covered restorative services under this Benefit Booklet:

- **Amalgam restorations,** limited to once per surface per tooth in any Benefit Period.
- **Composite restorations,** limited to once per surface per tooth in any Benefit Period.
- **Pin retention,** limited to once per tooth in any Benefit 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.

Endodontic Services

Dental services for the prevention, diagnosis, and treatment of diseases and injuries affecting the dental pulp, tooth root, and periradicular tissue. Covered Services include root canal fillings (filling the roots of teeth) and limited associated services, as listed below.

Root Canal Therapy

Coverage for root canal therapy includes a Treatment Plan, clinical procedures, postoperative radiographs, and follow-up care (all are included in the total root canal therapy allowance), limited to once per tooth in any three years and to permanent teeth only. Retreatment of root canal therapy will be covered only if existing root canal therapy is over three years old.

Other Endodontic Services

The following Covered Services are limited to a lifetime maximum of once per tooth/root:

- **Apexification/recalcification**.
- **Apicoectomy/periradicular services.** The Maximum Allowable Amount for Apicoectomy/periradicular services includes reimbursement for the removal of granulation tissue at the apex of the tooth. No additional benefit is available if the removal of granulation tissue at the apex of the tooth is billed separately from the Apicoectomy/periadicular service.
- **Retrograde filling**
- **Root amputation/hemisection**
- **Therapeutic pulpotomy (excluding final restoration),** limited to deciduous teeth only.

Oral Surgery Services

Treatment of certain dental conditions by operative or cutting procedures. Covered Services include tooth extractions, such as a single tooth or third molars (wisdom teeth), and other limited surgical procedures, as listed below. For surgical procedures related to the gums and to the bone that supports teeth, see "**Periodontal Services**." For root canal procedures, see "**Endodontic Services**."

- **Simple tooth extractions**
- **Surgical tooth extractions**
- **Alveoloplasty**
- **Vestibuloplasty**
- **Surgical Biopsy**
- **Excision of soft tissue lesions**
- **Excision of intra-osseous lesions**
- **Excision of bone tissue**
- **Frenulectomy**
- **Excision of hyperplastic tissue**
- **Surgical incision and drainage**
- A biopsy report must be submitted with claims for the removal of tumors, cysts, or neoplasms.

Periodontal Services

Dental services that treat diseases of the tissues that surround and support the teeth (e.g., the gums and the supporting bone). Covered Services include maintenance of the gum tissues and bone that supports the teeth, as listed below.

Periodontal Surgical Services

Coverage for periodontal surgical services includes routine postoperative care, limited to one surgical procedure per quadrant per Member in any three years.

Covered periodontal surgical services are:

- **Gingivectomy or gingivoplasty,** except 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)
- **Crown lengthening,** limited to once per tooth per lifetime.
- **Osseous surgery,** including flap entry with closure, limited to one osseous surgery per quadrant per member in any three years. Benefits are available for a particular quadrant only for treated teeth having 5 mm pockets or more.

- **Osseous grafts** are a Covered Service for replacement of bone loss due to periodontal disease. No benefit is available for Osseous Grafts done in conjunction with extraction sites, ridge augmentation, or in preparation for the placement of implants.
- **Soft tissue grafts**. The Maximum Allowable Amount 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 are billed separately.
- **Distal or proximal wedge procedure** is a Covered Service only when a periodontal pocket exists and the periodontal pocket measures 5mm or more. No additional benefit for the distal or proximal wedge procedure is available when periodontal surgery is performed in the same anatomical site and the distal or proximal wedge is billed separately.

Other Adjunctive Periodontal Services

Covered adjunctive periodontal services are:

- **Full-mouth debridement** to enable comprehensive periodontal evaluation and diagnosis (removal of subgingival and/or supragingival plaque and calculus), limited to a lifetime maximum of once per Member.
- **Periodontal scaling and root planing** if following osseous surgery or gingival flap procedure; however, six months must elapse between the time of osseous surgery or the gingival flap procedure, and the periodontal scaling and root planing.
- **Periodontal scaling and root planing** is limited to once per quadrant in any Benefit Period.
- **Periodontal maintenance procedures** only when following active periodontal therapy, limited to two cleanings per Benefit Period, whether routine or for periodontal maintenance.
- **Occlusal adjustment** (complete or limited) **and Occlusal guards** only if performed with osseous surgery or following osseous surgery received within the previous 12 months, limited to once in any three Benefit Periods.
- **Provisional splinting** (intracoronal or extracoronal) only if performed with osseous surgery or following osseous surgery received within the previous 12 months, limited to once in any three Benefit Periods.

Class III – Major Prosthodontic Services

Dental services that restore and maintain the oral function, comfort, and health of a patient by replacing missing teeth and surrounding tissue with artificial substitutes. Covered Services include crowns, bridges, partial dentures, complete dentures, and some services needed to support them, as listed below.

Bridge

A prosthetic dental Appliance that replaces lost teeth, being supported and held in position by attachments to adjacent teeth.

Crown

A restoration that reproduces the entire surface anatomy of the clinical crown of a tooth.

Denture

An artificial or prosthetic replacement for missing natural teeth and adjacent tissues.

Crowns/Onlays

Benefits for crowns/onlays, including benefits for the replacement of a lost or defective crown, are limited to once per tooth in any five years (whether placement was under this Plan or under any prior dental coverage, and even if the original crown was stainless steel or "temporary").

Crown or onlay benefits are available only if three or more surfaces of the tooth are being restored, or a cusp or incisal angle is missing, or the tooth has a completed root canal. If none of these criteria are met then the Maximum Allowable Amount for a crown or onlay is equal to the Maximum Allowable Amount that Plan would reimburse for a filling.

Other Covered Services related to crowns/onlays are:

- **Recementing of crowns/onlays,** limited to a lifetime maximum of once per crown/onlay.
- **Crown buildups** (includes pin retention), limited to once per tooth in any five benefit years (whether placement was under this product or under a prior dental coverage).
- **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 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,** limited to once per tooth in any five years (documentation must be supplied to verify completion of root canal therapy).
- **Crown/onlay repairs,** limited to once per crown/onlay in any five years.
- **Stainless steel crowns (for deciduous teeth only)**. Benefits are not provided for stainless steel crowns when used as a temporary crown.

Prosthodontics, Fixed

Fixed bridges are covered only when:

- The bridge is replacing functional teeth that were extracted after the member's effective date; and
- The total units required to replace all missing teeth is six units or less in an arch (arch means maxilla or mandible); and
- The bridge or bridges consist of no more than six (6) units total in an arch. (Each abutment is a unit and each pontic is a unit in a bridge).

Note: Benefits are provided for the replacement of an existing bridge if it is five years old or older and either cannot be made serviceable or has been lost or stolen. Benefits will not be provided for a pontic or an abutment if an Appliance or crown/onlay was placed on the affected tooth/teeth in the last five years.

Note: Fixed Prosthodontics are not a Covered Service when all molars are missing on one or both sides of an arch. However, Removable Prosthodontics may be a Covered Service. Please see Prosthodontics, Removable below.

Note: The Maximum Allowable Amount for fixed bridgework that includes more than a total of six (6) units is limited to the Maximum Allowable Amount Plan would pay for a removable partial denture.

- **Recementing a bridge,** limited to a lifetime maximum of once per bridge.
- **Post and core buildups,** limited to once per tooth in a five-year period. (Documentation must be supplied to verify completion of root canal therapy.)
- **Bridge repair,** limited to once per bridge in a five-year period.

Prosthodontics, Removable

The Maximum Allowable Amount for these services includes routine post-delivery care. Covered Services include:

- Removable complete immediate or permanent and partial dentures, but only if the tooth/teeth being replaced were functional and 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 Appliance is five years old or older and either cannot be made serviceable or has been lost or stolen.

Covered Services for both complete and partial dentures include:

- **Adjustments,** limited to once per Appliance in a Benefit Period.
- **Repairs,** (unless repairs are completed on the same date as replacement partials/dentures), limited to once per Appliance in a five year period.
- **Addition of tooth or clasp** (unless additions are completed on the same date as replacement partials/dentures), limited to a lifetime maximum of once per tooth.
- **Denture rebase and reline procedures,** limited to once per Benefit Period for chair side relining and once in three years for laboratory rebasing or relining.

Class IV - Orthodontic Services

Non-surgical dental services related to the supervision, guidance, and correction of growing or mature teeth. 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 benefit limit. **Refer to the Schedule of Benefits for Orthodontic Age Limitations.**

For each eligible Member, after the Deductible (if any) is met, the Plan pays the applicable percentage shown in the Schedule of Benefits of the Maximum Allowable Amount for the following orthodontic services:

- **Diagnostic orthodontic records,** limited to a lifetime maximum of once per eligible Member.
- **Minor treatment for tooth guidance.**
- **Minor treatment to control harmful habits.**
- **Interceptive orthodontic treatment.**
- **Comprehensive orthodontic treatment,** transitional and permanent dentition.
- **Post-treatment stabilization,** limited to a lifetime maximum of one Appliance per eligible Member.

Pretreatment Estimates and Treatment Plans

A Written Pretreatment Estimate is available from The Claims Administrator, on behalf of the Employer. Either You or Your Provider may submit a request for a Pre-treatment Estimate. If Your Provider is a Network Provider, he or she will be familiar with the process and will submit the request on Your behalf. In order for Plan to complete a Pretreatment Estimate, Your Provider will need to submit a written Treatment Plan, with the required documentation for the services. Requests should be submitted on a standard claim form. Telephone requests cannot be accepted. Mail the Pretreatment Estimate request and Treatment Plan forms to the address listed on Your Identification Card.

The Plan will send to the Member and the Provider of service a written estimate of Covered Services, benefit amounts payable, Deductible amount due, and maximum limitation amounts. The Plan's Pretreatment Estimates are valid for 120 days, provided all other eligibility and Plan requirements are met. If the procedure is not completed within the time period set forth in the Pretreatment Estimate, or if the patient's condition changes, You should ask Your Provider to submit another request and Treatment Plan, along with the required, current documentation. A new Pretreatment Estimate will then be completed by the Plan.

Regardless of a Pretreatment Estimate, coverage under this Plan must be maintained without interruption through the date that services are performed in order for benefits to be provided.

Missing Tooth Waiver

Covered services include removable Prosthodontics (partials or dentures) or fixed Prosthodontics (bridges) for the replacement of teeth (or tooth) lost prior to the member's effective date of coverage under this Plan.

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 not to be Covered Services.

The Plan does not provide dental benefits for services or supplies:

1. Received from an individual or entity that is not a Provider, as defined in this Benefit Booklet.

2. Procedures not yet recognized by the American Dental Association as indicated with a specific procedure code designation.

3. For any condition, disease, defect, aliment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. This exclusion applies if You receive the benefits in whole, or in part. This exclusion also applies whether or not You claim the benefits or compensation. It also applies whether or not You recover from any third party.

4. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

5. For illness or injury that occurs as a result of any act of war, declared or undeclared.

6. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.

7. For which You have no legal obligation to pay in the absence of this or like coverage.

8. Received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trust or similar person or group.

9. Prescribed, ordered, or referred by, or received from a member of Your immediate family, including Your spouse, child, brother, sister, parent, or self.

10. For completion of claim forms or charges for medical records or reports unless otherwise required by law.

11. For missed or canceled appointments.

12. Charges in excess of the Maximum Allowable Amount.

13. Incurred prior to Your Effective Date.

14. Incurred after the termination date of this coverage except as specified elsewhere in this Benefit Booklet.

15. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

16. For dental services or supplies for treating congenital malformations or for cosmetic or esthetic purposes.

17. For services and supplies for replacing lost, missing, or stolen dental prosthetic devices.

18. For any dental service or supply not billed by a Dentist.

19. For dental services or supplies furnished as a result of loss or theft of an artificial denture or orthodontic appliance.

20. For dental services performed by a Dentist in Your home or in a Provider facility, except when performed in connection with oral surgery or with Emergency Care.

21. For services and supplies not administered in accordance with accepted standards of dental practice, as determined by the Administrator's dental Subcontractor.

22. For services and supplies for dental sealants.

23. For services or supplies for repair or replacement of an orthodontic appliance.

24. For duplicate dental appliances.

25. For orthodontic services after the date in which the Member reaches age 19.

26. For charges for gold, silver, or precious gems when used as fillings, inlays, and onlays to restore diseased or accidentally broken teeth.

27. No Benefits are available for services that are not specifically described as Covered Services in this Benefit Booklet. This exclusion applies even if Your Physician orders the service.

HOW MAXIMUM ALLOWABLE AMOUNT IS DETERMINED

General

This section describes how the Plan determines the amount of reimbursement for Covered Services. Reimbursement for dental services rendered by Network and Non-Network Dentists is based on this Plan's Maximum Allowed Amount for the type of service performed.

The Maximum Allowed Amount for this Plan is the maximum amount of reimbursement the Plan will pay for services and supplies:

- that meet the Plan's definition of Covered Services, to the extent such services and supplies are covered under Your Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in Your Benefit Booklet.

You will be required to pay a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. In addition, when You receive Covered Services from a Non-Network Dentist, You may be responsible for paying any difference between the Maximum Allowed Amount and the Dentist's actual charges. This amount can be significant.

When You receive Covered Services from a Dentist, the Plan will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the dental procedure. Applying these rules may affect the Claims Administrator's determination of the Maximum Allowed Amount. The Claims Administrator's application of these rules does not mean that the Covered Services You received were not Medically Necessary. It means the Claims Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, Your Dentist may have submitted the claim using several procedure codes when there is a single procedure code that includes all or a combination of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same dental Provider or other dental Providers, the Plan may reduce the Maximum Allowed Amounts for those additional procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent a duplicate payment for a dental procedure that may have already been considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is a Network Dentist or a Non-Network Dentist.

Network Dentist

A Network Dentist or participating Dentist is a Dentist who is in the contracted network for this specific product or who has participation contract with the Claims Administrator. For Covered Services performed by a Network Dentist or participating providers, the Maximum Allowed Amount for this Plan is the rate the Dentist has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because Network Dentists and participating providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send You a bill or collect for amounts above the Maximum Allowed Amount. However, You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible, or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Network Dentist or participating provider or visit www.anthem.com.

Non-Network Dentist

Dentists who have not signed any contract with the Claims Administrator and are not in any of the Claims Administrator's networks are Non-Network Dentists.

For Covered Services You receive from a Non-Network Dentist, the Maximum Allowed Amount for this Plan will be one of the following:

1. An amount based on the Claims Administrator's Non-Participating provider fee schedule/rate, which the Claims Administrator has established in its discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: record fee data, reimbursement amounts accepted by like/similar providers contracted with the Claims Administrator, reimbursement amounts accepted by like/similar providers for the same services or supplies, or other industry cost, reimbursement and utilization data; or

2. An amount based on information provided by a third party vendor which may reflect comparable Providers' fees and costs to deliver care; or

3. An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Network Provider; or

4. An amount equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

Providers who are not contracted for this product but contracted for other products with the Claims Administrator are also considered Non-Network. For this Plan, the Maximum Allowed Amount for services from these Providers will be one of the four methods shown above unless the contract between the Claims Administrator and that Provider specifies a different amount.

Unlike Network Dentists or participating providers, Non-Network Dentists may send You a bill and collect for the amount of the Dentist's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Dentist charges. This amount can be significant. Choosing a Network Dentist or participating Dentist will likely result in lower out of pocket costs to You. Please call Customer Service for help in finding a Network Dentist or visit the Claims Administrator's website at www.anthem.com.

Customer Service is also available to assist You in determining this Plan's Maximum Allowed Amount for a particular service from a Non-Network Dentist. In order for the Claims Administrator to assist You, You will need to obtain from Your Dentist the specific procedure code(s) for the services the Dentist will render. You will also need to know the Dentist's charges to calculate Your Out-of-Pocket responsibility. Although Customer Service can assist You with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted by the Dentist.

Member Cost Share

For certain Covered Services and depending on Your plan design, You may be required to pay a part of the Maximum Allowed Amount as Your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and out of pocket limits may vary depending on whether You received services from a Network or Non-Network Dentist. Specifically, You may be required to pay higher cost sharing amounts or may have limits on Your benefits when using Non-Network Dentists. Please see the Schedule of Benefits in this Benefit Booklet for Your cost share responsibilities and limitations, or call Customer Service to learn how this Plan's benefits or cost share amounts may vary by the type of Dentist You use.

The Plan will not provide any reimbursement for non-covered services. You may be responsible for the total amount billed by Your Dentist for non- covered services, regardless of whether such services are performed by a Network or Non-Network Dentist. Both services specifically excluded by the terms of Your Plan and those received after benefits have been exhausted are non-covered services. Benefits may be exhausted by exceeding, for example, Your annual or lifetime maximum, benefit maximums or day/visit limits.

CLAIMS PAYMENT

Payment of Benefits

You authorize the Plan to make payments directly to Providers giving Covered Services for which are provided benefits under the Plan. The Employer reserves the right to make payments directly to You.

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.

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

Assignment

The coverage and any benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above.

Notice of Claim

The Plan is not liable, unless the Claims Administrator receives written notice that Covered Services have been given to You. The notice must be given to the Claims Administrator within 90 days of receiving the Covered Services, and must have the data the Claims Administrator needs to determine benefits. If the notice submitted does not include sufficient data the Claims Administrator needs to process the claim, then the necessary data must be submitted to the Claims Administrator within the time frames specified in this provision or no benefits will be payable except as otherwise required by law.

If the Claims Administrator has not received the information it needs to process a claim, the Claims Administrator will ask for the additional information necessary to complete the claim. Generally, You will receive a copy of that request for additional information, for Your information. In those cases, the Claims Administrator cannot complete the processing of the claim until the additional information requested has been received. The Claims Administrator generally will make its request for additional information within 30 days of the Claims Administrator's initial receipt of the claim and will complete the Claims Administrator's processing of the claim within 15 days after the Claims Administrator's receipt of all requested information. An expense is considered incurred on the date the service or supply was given. **If the Claims Administrator is unable to complete processing of a claim because You or Your Provider fail to provide the Claims Administrator with the additional information within 60 days of its request, the claim will be denied and You will be financially responsible for the claim.**

Failure to give the Claims Administrator notice within 90 days will not reduce any benefit if You show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Many Providers will file for You. If the forms are not available, either send a written request for claim forms to the Claims Administrator or the Employer, 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 the Claims Administrator, on behalf of the Employer, 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 Dentist's signature

Time Benefits Payable

The Plan will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by You or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If the Claims Administrator has not received the information needed to process a claim, the Claims Administrator, on behalf of the Employer, will ask for the additional information necessary to complete the claim. Generally, You will receive a copy of that request for additional information, for Your information. In those cases, the Claims Administrator cannot complete the processing of the claim until the additional information requested has been received. The Claims Administrator, on behalf of the Employer, generally, will make a request for additional information within 30 days of the Claims Administrator or Employer's initial receipt of the claim and will complete processing of the claim within 15 days after the Claims Administrator's receipt of all requested information.

At the Employer's discretion, benefits will be paid to You or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, the Plan may reimburse those other parties and be fully discharged from that portion of its liability.

Member's Cooperation

Each Member shall complete and submit to the Claims Administrator, on behalf of the Employer, such authorizations, consents, releases, assignments, and other documents as may be requested by the Claims Administrator, in order to obtain or assure reimbursement under Workers' Compensation or any other governmental program. Any Member who fails to cooperate will be responsible for any charge for services.

Claims Review

The Claims Administrator has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Explanation of Benefits

After You receive medical care, You will generally 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 sent by the Claims Administrator, on behalf of the Employer, 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.

GENERAL PROVISIONS

Entire Agreement

This Benefit Booklet, the Administrative Services Agreement, the Employer's application, any Riders, Endorsements or attachments, and the individual applications of the Subscribers and Members, if any, constitute the entire agreement between the Claims Administrator and the Employer and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Claims Administrator by the Employer, and any and all statements made to the Employer by the Claims Administrator, are representations and not warranties, and no such statement unless it is contained in a written application for coverage under the Plan, shall be used in defense to a claim under the Plan.

Form or Content of Benefit Booklet

No agent or employee of the Claims Administrator is authorized to change the form or content of this Benefit Booklet. Such changes can be made only through an endorsement authorized and signed by an officer of the Employer.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the Dentist-patient relationship and as obstructing the provision of proper dental care. Providers shall use their best efforts to render all dental care services in a manner compatible with Your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper dental practice.

If You refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, You will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

The Claims Administrator, on behalf of the Employer, shall make a good-faith effort to arrange for an alternative method of administering benefits. In the event of circumstances not within the control of the Claims Administrator or Employer, including but not limited to: a major disaster, epidemic, and the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of the Claims Administrator, disability of a significant part of a

Network Provider's personnel or similar causes, or the rendering of health care services provided by the Plan is delayed or rendered impractical. In such event, the Claims Administrator and Providers shall administer and render services under the Plan insofar as practical, and according to their best judgment; but the Claims Administrator and Providers shall incur no liability or obligation for delay, or failure to administer or arrange for services if such failure or delay is caused by such an event.

Not Liable for Provider Acts or Omissions

The Claims Administrator and/or the Employer are not responsible for the actual care You receive from any person. The Plan does not give anyone any claim, right, or cause of action against the Claims Administrator and/or the Employer based on what a Provider of health care, services or supplies, does or does not do.

Identification Card

When You receive care from Your Provider, You must show Your Identification Card. Possession of an Identification Card confers no right to services or other benefits under the Plan. To be entitled to such services or benefits You must be a Member on whose behalf all applicable Fees under the Plan have been paid. Any person receiving services or other benefits to which he or she is not then entitled under the provisions of the Plan will be responsible for the actual cost of such services or benefits.

Protected Health Information Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. Your Employer's Group Health Plan has a responsibility under the HIPAA Privacy Regulations to provide You with a Notice of Privacy Practices. This notice sets forth the Employer's rules regarding the disclosure of Your information and details about a number of individual rights You have under the Privacy Regulations. As a Claims Administrator of Your Employer's Plan, Anthem has also adopted a number of privacy practices and has described those in its Privacy Notice. If You would like a copy of Anthem's Notice, contact the customer service number on the back of Your Identification Card.

Coordination of Benefits

This Coordination of Benefits (COB) provision applies when You have dental care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Benefit Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Benefit Booklet, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determine the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

Because the Allowable expense may be the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider may be allowed to bill You for any remaining Coinsurance, Deductible, and/or Copayment under the higher allowable amount. This higher allowable amount may be more than the Plan's allowed amount.

COB Definitions

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

2. Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing dental care benefits that the COB provision applies to and which may be reduced because of the benefits of other plans. Any other part of the contract providing dental care benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether this Plan is a Primary Plan or Secondary Plan when You have dental care coverage under more than one Plan.

When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health or dental care expense, including Deductibles and/or Coinsurance that is covered at least in part by any Plan covering You. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering You is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging You is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

1. If You are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

2. If You are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

3. If You are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.

4. The amount of any benefit reduction by the Primary Plan because You have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, Precertification of admissions or services, and Network Provider arrangements.

Closed panel plan is a Plan that provides dental care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order Of Benefit Determination Rules

When You are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

1. Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.

2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers You other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers You as a Dependent is the Secondary Plan. However, if You are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering You as a Dependent and primary to the Plan covering You as other than a Dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering You as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering You as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

    - If a court decree states that one of the parents is responsible for the Dependent child's dental care expenses or dental care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

    - If a court decree states that both parents are responsible for the Dependent child's dental care expenses or dental care coverage, the provisions of 1. above will determine the order of benefits;

    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental care expenses or dental care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or

    - If there is no court decree assigning responsibility for the Dependent child's dental care expenses or dental care coverage, the order of benefits for the child are as follows:

        - The Plan covering the Custodial parent;

        - The Plan covering the spouse of the Custodial parent;

        - The Plan covering the non-custodial parent; and then

        - The Plan covering the spouse of the non-custodial parent.

3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers You as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering You as a retired or laid-off employee is the Secondary Plan. The same would hold true if You are a Dependent of an active employee and You are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - Longer or Shorter Length of Coverage. The Plan that covered You longer is the Primary Plan and the Plan that covered You the shorter period of time is the Secondary Plan.

Rule 6 - If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

Effect On The Benefits Of This Plan

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill You for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If You are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

Right to Receive and Release Needed Information

Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. The Claims Administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claims Administrator any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under this Plan. If it does, this Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. This Plan 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 the 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 paid under this COB provision, the Claims Administrator, may recover the excess from one or more of the persons:

1. The Plan has paid or for whom the Plan have paid; or
2. Any other person or organization that may be responsible for the benefits or services provided for the Member.

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

Workers' Compensation

The benefits under the Plan are not designed to duplicate any benefit for which Members are eligible under the Workers' Compensation Law. All sums paid or payable by Workers' Compensation for services provided to a Member 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 Workers' Compensation.

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payor, the benefits under the Plan 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 Right of Reimbursement

These provisions apply when the Plan pays benefits as a result of injuries or illnesses You sustained and You have a right to a Recovery or have received a Recovery from any source.

Recovery

A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, Workers' Compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how You or Your representative or any agreements characterize the money You receive as a Recovery, it shall be subject to these provisions.

Subrogation

The Plan has the right to recover payments it makes on Your behalf from any party responsible for compensating You for Your illnesses or injuries. The following apply:

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether You are fully compensated, and regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.

- You and Your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.

- In the event that You or Your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.

- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by You, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs.

- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs You incur without the Plan's prior written consent. 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 the Plan.

Reimbursement

If You obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on Your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on Your behalf and the following provisions will apply:

- You must reimburse the Plan from any Recovery to the extent of benefits the Plan paid on Your behalf regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.

- Notwithstanding any allocation or designation of Your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to Your negligence.

- You and Your legal representative must hold in trust for the Plan 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 the Plan immediately upon Your receipt of the Recovery. You must reimburse the Plan, 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 the Plan.

- If You fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of Your Recovery whichever is less, from any future benefit under the Plan if:

  - The amount the Plan paid on Your behalf is not repaid or otherwise recovered by the Plan; or
  - You fail to cooperate.

- In the event that You fail to disclose the amount of Your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.

- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of Your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse You.

- The Plan is 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 You or make You whole.

Your Duties

- You must notify the Plan 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 the Plan in the investigation, settlement and protection of the Plan's rights. In the event that You or Your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

- You must not do anything to prejudice the Plan's rights.

- You must send the Plan 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 the Plan if You retain an attorney or if a lawsuit is filed on Your behalf.

The Plan Sponsor has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person that Recovery shall be subject to this provision.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by You to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

Right of Recovery

Whenever payment has been made in error, the Claims Administrator, on behalf of the Employer, will have the right to recover such payment from You or, if applicable, the Provider. The Claims Administrator, on behalf of the Employer, reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

The Claims Administrator, on behalf of the Employer, has oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. The Claims Administrator, on behalf of the Employer, 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. The Claims Administrator, on behalf of the Employer, has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery

amounts. The Claims Administrator, on behalf of the Employer, will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The Claims Administrator, on behalf of the Employer, may not provide You with notice of overpayments made by the Plan or You if the recovery method makes providing such notice administratively burdensome.

Relationship of Parties (Employer-Member-Claims Administrator)

Neither the Employer nor any Member is the agent or representative of the Claims Administrator.

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

Anthem Insurance Companies, Inc. Note

The Employer, on behalf of itself and its participants, hereby expressly acknowledges its understanding that the Administrative Services Agreement (which includes this Benefit Booklet) constitutes a contract solely between the Employer and Anthem Insurance Companies, Inc. (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of Indiana. 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 the Administrative Services Agreement or this Benefit Booklet.

Notice

Any notice given under the Plan shall be in writing. The notices shall be sent to: The Employer at its principal place of business; to You at the Subscriber's address as it appears on the records or in care of the Employer.

Modifications

This Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions by the Employer, or by mutual agreement between the Claims Administrator and the Employer without the consent or concurrence of any Member. By electing dental benefits under the Plan or accepting the Plan benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

Conformity with Law

Any provision of the Plan, which is in conflict with the applicable federal laws and regulations is hereby amended to conform with the minimum requirements of such laws.

Clerical Error

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

Policies and Procedures

The Claims Administrator, on behalf of the Employer, may adopt reasonable policies, procedures, rules, and interpretations to promote the orderly and efficient administration of the Plan with, which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Employer, has authority to waive any conditions or restrictions of the Plan, to extend the 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.

Employer's Sole Discretion

The Employer may, in its sole discretion, cover services and supplies not specifically covered by the Plan. This applies if the Employer, with advice from the Claims Administrator, 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

Anthem shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation of the Plan and interpretation of the Benefit Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement, to determine all questions arising under the Plan, to resolve Member Complaints and Appeals and to make, establish and amend the rules, regulations, and procedures with regard to the interpretation of the Benefit Booklet of the Plan. A specific limitation or exclusion will override more general benefit language. Anthem has complete discretion to interpret the Benefit Booklet. Anthem's determination shall be final and conclusive and may include, without limitation, determination of whether the charges for services, treatment, or supplies are consistent with the Plan's Maximum Allowable Amount. A member may utilize all applicable Complaint and Appeals procedures.

COMPLAINT AND APPEALS PROCEDURES

The Claims Administrator's customer service representatives are specially trained to answer Your questions about Your health benefit Plan. Please call during business hours, Monday through Friday, with questions regarding:

- Your coverage and benefit levels, including Copayment amounts;
- specific claims or services You have received;
- referral processes or authorizations; and/or
- Provider directories.

A complaint procedure has been established to provide fair, reasonable, and timely review of complaints that You may have concerning the Plan. The Claims Administrator invites You to share any concerns that You may have over benefit determinations, coverage cancellations, or the quality of care rendered by dental Providers.

The Complaint Procedure

If You have a complaint, problem, or claim concerning benefits or services, please contact the Claims Administrator. Please refer to Your Identification Card for the Claims Administrator's address and telephone number.

A complaint is an expression of dissatisfaction that can often be resolved by an explanation from the Claims Administrator of its procedures and contracts. You may submit Your complaint by letter or by telephone call. Or, if You wish, You may meet with Your local service representative to discuss Your complaint. If Your complaint involves issues of Covered Services, You may be asked to sign a dental records release form so the Claims Administrator can request dental records for its review.

The Appeals Procedure

As a member of the Plan, You have the right to appeal decisions to deny or limit the Plan benefits. You may also file an appeal to address concerns regarding confidentiality or privacy. Appeals should be filed with the Claims Administrator for review in accordance with the procedures set forth below.

Claims Administrator Appeals

An appeal is a request from You for the Claims Administrator to change a previous determination made. An initial determination by the Claims Administrator can be appealed for further review by the Claims Administrator at two subsequent levels known as "Level 1" and "Level 2" appeals. The Claims Administrator will advise You of Your rights to the next level of review if a denial is upheld after a Level 1 appeal or a Level 2 appeal.

You have the right to designate a representative (e.g. Your Dentist) to file an appeal on Your behalf and to represent You in the appeal. If a representative is seeking an appeal on Your behalf, the Claims Administrator must obtain a signed Designation of Representation form from You before the Claims Administrator can begin processing Your appeal unless a Dentist is requesting expedited review of a Level 1 appeal on Your behalf. If that occurs, the Dentist will be deemed to be Your representative for the purpose of filing the expedited Level 1 appeal without receipt of a signed form.

Once an appeal has been filed as described below, the Claims Administrator will accept oral or written comments, documents or other information relating to Your appeal from You, Your designated representative or Your Provider by telephone, facsimile or other reasonable means. You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to Your appeal.

Level 1 Appeals

Level 1 appeals are reviewed by a person who did not make the initial determination and who is not the subordinate of the initial reviewer. If a clinical issue is involved, the Claims Administrator will use a clinical peer for this review unless Your appeal concerns an adverse voluntary predetermination decision or unless the adverse decision can be overturned based upon prescreening by a nurse or other qualified reviewer. A clinical peer is a Dentist or Provider who has the same license as the Provider who will perform or has performed the service.

The Claims Administrator requires its members to submit all requests for appeal in writing. Written appeal requests, including a detailed description of the problem and all relevant information, should be sent to Attention: National Appeals; Anthem Blue Cross and Blue Shield; P.O. Box 659471; San Antonio, TX 78265-9471, or to the address (or phone number), provided for filing an appeal on any written notice of an adverse decision that You receive from the Claims Administrator.

If You are appealing an adverse pre-authorization decision or the denial of any prior approval required by the Plan, the Claims Administrator will provide You with a written response indicating the Plan's decision within a reasonable period of time appropriate to the dental circumstances but not later than 20 business days of the date the Claims Administrator receives Your Level 1 appeal request. If more information is needed to make a decision on Your appeal,

the Claims Administrator will send a written request for the information after receipt of the appeal. No extensions of time for additional information may be taken on these Level 1 appeals without the permission of the member. Therefore, the Claims Administrator will make a decision based upon the available information if the additional information requested is not received.

If You are appealing any other type of adverse decision and sufficient information is available to decide the appeal, the Claims Administrator will resolve Your Level 1 appeal within a reasonable period of time but not later than 30 business days from receipt of the Level 1 appeal request. If more information is needed to make a decision on Your appeal, the Claims Administrator shall send a written request for the information after receipt of the appeal. If the additional information requested is not received within 30 business days of the Level 1 appeal request, the Claims Administrator shall conduct its review based upon the available information, which review shall be completed within a reasonable period of time but not later than 40 business days from receipt of the Level 1 appeal request. After the Level 1 appeal decision is made, You will be notified within five business days in writing by the Claims Administrator of the Plan's decision concerning Your Level 1 appeal.

Level 2 Appeals

If You are dissatisfied with the Level 1 appeal decision, You may request a Level 2 appeal. At Level 2, the appeal is reviewed by a panel of the Claims Administrator's staff members. You have a right to personal appearance before the Level 2 appeals panel. Level 2 appeals concerning the denial of any prior approval required by the Plan will be resolved by the panel no later than 30 calendar days from the date Your Level 2 appeal request was received by the Claims Administrator. All other Level 2 appeals will be resolved by the panel no later than 45 business days from the date Your Level 2 appeal request was received by the Claims Administrator. After the appeal panel makes a decision You will be notified within five business days in writing by the Claims Administrator of the Plan's decision concerning Your Level 2 appeal.

Expedited Reviews

Any level of appeal can be expedited if:

- The service at issue has not been performed; and

- Your Provider believes that the standard appeal timeframes could subject You to severe pain that cannot be adequately managed.

The Claims Administrator will complete expedited review of a Level 1 appeal as soon as possible taking into account the medical urgency of the situation but not later than forty-eight hours (48 hours) after the Claims Administrator receives the Level 1 appeal request and will communicate the Plan's decision by telephone to Your attending Dentist or the ordering Provider.

The Claims Administrator will also provide written notice of the Plan's determination to You, Your attending Dentist, or ordering Provider, and the facility rendering the service. The Claims Administrator will complete expedited review of a Level 2 appeal as expeditiously as the medical condition requires and panel administration permits. The Plan's decision will be communicated by telephone to Your attending Dentist or the ordering Provider. The Claims Administrator will also provide written notice of the Plan's determination to You, Your attending Dentist, or ordering Provider, and to the facility rendering the service.

External Appeals

If You are dissatisfied with the Plan's Level 2-appeal decision, an "External Appeal" may be available. External Appeal is available after all other appeal rights with the Claims Administrator are exhausted. In a case of urgently needed care, the Claims Administrator may elect to bypass some levels of appeal to send a case directly to an External Appeal. An External Appeal is not available for services or supplies that are limited or excluded by contract.

Appeals Filing Time Limit

You are encouraged to file Level 1 appeals on a timely basis. The Claims Administrator will not review a Level 1 appeal if it is received after the end of the calendar year plus 12 months since the incident leading to the Member's appeal. Level 2 appeals must be filed within 60 days of receipt of notice of the Level 1 appeal determination. An External Appeal must be filed within 60 days from receipt of the Plan's Level 2 appeal decision.

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.