

DENTAL BENEFIT BOOKLET

DIOCESE OF FORT WAYNE – SOUTH BEND, INC.
PPO Dental Plan
Effective 1/1/2007

BENEFIT BOOKLET

This Benefit Booklet has been prepared by the 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 dental 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. The Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.**

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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.

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

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

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.

Benefit Booklet - This summary of the terms of your dental 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.

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.

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 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 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.

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. You must be Actively at Work on your Effective Date. If you are not Actively at Work on your Effective Date, your Effective Date will be the date you become Actively at Work. 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.

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 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).

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.

Identification Card - A card issued by the 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.

Late Enrollee - An individual whose enrollment under the Plan is a Late Enrollment.

Late Enrollment - Enrollment other than on:

- The earliest date on which benefits can become effective under the Plan; or

Maximum Allowable Amount - The Maximum Dollar Amount allowed toward the cost of a covered dental service as specified in this Benefit Booklet. The Administrator determines a dollar amount that represents the total obligation with respect to payment for Covered Services. The Maximum Dollar Amount does not necessarily represent the Provider's full fee for that service.

A Network of Providers participates with the Administrator and/or the Subcontractor. You always receive the maximum benefits available for Covered Services when you use a Participating Network Provider. Network Providers have agreed to accept the Maximum Allowable Amount as payment in full for Covered Services. If you receive Covered Services from a Non-Network Provider, you are responsible for the difference between the Maximum Allowable Amount and the Provider's actual charge, plus any Deductible and/or Coinsurance as described in this Benefit Booklet. You are also responsible for the Provider's actual charges for non-covered services whether you use a Network or Non-Network Provider.

Medically Necessary -are procedures, supplies, equipment, or services that are:

1. appropriate for the symptoms, diagnosis, or treatment of a dental condition, and
2. provided for the diagnosis or direct care and treatment of the dental condition, and
3. within the standards of good dental practice within the organized dental community, and
4. not primary for the convenience of the patient's Dentist or another provider, and
5. the most appropriate procedure, supply, equipment, or service must satisfy the following requirements:
 - There must be valid scientific evidence demonstrating that the expected benefits from the procedure, supply or service are clinically significant ; and
 - Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable.

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."

Network Provider - A Provider who has entered into a contractual agreement or is otherwise engaged by the Administrator, or with another organization, which has an agreement with the Administrator, regarding payment for Covered Services and certain administration functions for the Network associated with the Plan.

Non-Network Provider - A Provider who has not entered into a contractual agreement with the Administrator for the Network associated with the Plan. Providers who have not contracted or affiliated with the Administrator's designated Subcontractor(s) for the services they perform under this Plan are also considered Non-Network Providers.

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

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.

Provider - A duly licensed person or facility that provides dental services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any legally licensed Provider rendering services, which are required by applicable state law to be covered when rendered by such Provider. Providers include, but are not limited to, the following persons and facilities:

- **Dentist** -- A duly licensed dentist who is performing services within the scope of his or her license.

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.

Subcontractor - The Administrator and/or Employer may subcontract particular services to organizations or entities that have specialized expertise in certain areas. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on the Administrator or Employer's behalf.

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 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 cause the Employee to be a Late Enrollee at the time of future enrollment 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 cause the Dependents to be Late Enrollees at the time of future enrollment unless the Dependent 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 cause such Dependent to be a late Enrollee at the time of future enrollment 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. the legal Spouse of the Employee; 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) be unmarried;
 - (ii) be dependent upon the Employee for more than one-half of their annual support;
 - (iii) be less than age 19 or be a Full-Time Student over age 19 but less than age 23 at an accredited College, University or Trade School maintaining at least 12 credit hours of coursework per semester.
- c. a child born to a mother who satisfies the criteria of this Section (3) b., for the first six months of that child's life after the date of birth.

The support requirement as it pertains to a child is waived if the Employee is required to provide coverage due to court order, divorce decree, a Qualified Medical Child Support Order or any other legal decree.

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 19 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) Application for coverage at any other time that does not qualify as a Special Enrollment shall constitute late application and the person is subject to Late Enrollee provisions.
- (6) For a Late Enrollee, the effective date of coverage is January 1st following application during Open Enrollment Period.

- (7) 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
 - c. for a Late Enrollee, the effective date of coverage is January 1st following application during Open Enrollment Period.

Late Enrollee

A person who enrolls at a time other than when first eligible, except for a Special Enrollment or Dependent Special Enrollment event, is a Late Enrollee. A Late Enrollee is not subject to the Waiting Period.

A Late Enrollee may apply for coverage during Open Enrollment for coverage to be effective on January 1st.

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 a Late Enrollee and 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. In this event, the enrollee(s) are subject to Late Enrollee provisions.

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 a Late Enrollee and 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

if enrollment in this Plan occurs more than 30 days following the loss of other coverage, the date of enrollment in this Plan. In this even, the enrollee(s) are subject to Late Enrollee provisions. For a newborn or adopted child, coverage is retroactive to the date of birth or date of adoption.

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 same rules of termination apply to the end of Dependent coverage.

For Retirees and covered Dependents of Retirees, there are termination of coverage events that are in addition to the other termination of coverage events stated in this paragraph:

- (7) Upon attaining age 65
- (8) Upon becoming eligible for Medicare.
- (9) Upon becoming eligible for other group coverage.

In addition to any other Termination of Coverage provisions, a student will terminate on the earliest of the dates described as follows:

- (1) the date any of the dependent criteria are no longer satisfied;
- (2) the date enrollment as a Full-Time Student ends;
- (3) September 1, annually, if enrolled as a Full-Time Student on the last day of the prior Spring term unless the Plan Administrator receives satisfactory confirmation that the dependent will continue studies as a Full-Time Student.
- (4) the date of class graduation following completion of High School, under-graduate or post-graduate study unless the Plan Administrator receives satisfactory confirmation that the dependent will continue studies as a Full-Time Student.

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

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

The 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 Administrator or your Provider.

Not Liable for Provider Acts or Omissions

The 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 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 Administrator, on behalf of the Employer, for diagnostic evaluation. The 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/periradicular 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 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:

- Received from an individual or entity that is not a Provider, as defined in this Benefit Booklet.
- Procedures not yet recognized by the American Dental Association as indicated with a specific procedure code designation.
- For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's 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.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For illness or injury that occurs as a result of any act of war, declared or undeclared.
- For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
- For which you have no legal obligation to pay in the absence of this or like coverage.
- 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.
- Prescribed, ordered, or referred by, or received from a member of your immediate family, including your spouse, child, brother, sister, parent, or self.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.

- Charges in excess of the Maximum Allowable Amount.
- Incurred prior to your Effective Date.
- Incurred after the termination date of this coverage except as specified elsewhere in this Benefit Booklet.
- For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
- For dental services or supplies for treating congenital malformations or for cosmetic or esthetic purposes.
- For services and supplies for replacing lost, missing, or stolen dental prosthetic devices.
- For any dental service or supply not billed by a Dentist.
- For dental services or supplies furnished as a result of loss or theft of an artificial denture or orthodontic appliance.
- 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.
- For services and supplies not administered in accordance with accepted standards of dental practice, as determined by the Administrator's dental Subcontractor.
- For services and supplies for dental sealants, except as specified under Covered Services.
- For services or supplies for repair or replacement of an orthodontic appliance.
- For duplicate dental appliances.
- For orthodontic services after the date in which the Member reaches age 19.
- For charges for gold, silver, or precious gems when used as fillings, inlays, and onlays to restore diseased or accidentally broken teeth.

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 Administrator, on behalf of the Employer receives written notice that Covered Services have been given to you. An expense is considered incurred on the date the service or supply was given.

The notice must be given to the Administrator within 90 days of receiving the Covered Services, and must have the data the Administrator needs to determine benefits. If the notice submitted does not include sufficient data the Administrator needs to process the claim, then the necessary data must be submitted to the Administrator within the time frames specified in this provision or no benefits will be payable except as otherwise required by law. Failure to give the 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 can be submitted later than one year after the usual 90-day filing period ends.

Note: You have the right to obtain an itemized copy of your billed charges from the Hospital or facility, which provided services.

Claim Forms

Many Providers will file for you. If the forms are not available, either send a written request for claim forms to the 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 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 Administrator has not received the information needed to process a claim, the 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 Administrator cannot complete the processing of the claim until the additional information requested has been received. The Administrator, on behalf of the Employer, generally, will make a request for additional information within 30 days of the Administrator or Employer's initial receipt of the claim and will complete processing of the claim within 15 days after the 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 Administrator, on behalf of the Employer, such authorizations, consents, releases, assignments, and other documents as may be requested by the Administrator, in order to obtain or assure reimbursement under Worker's Compensation or any other governmental program. Any Member who fails to cooperate will be responsible for any charge for services.

Explanation of Benefits

After you receive 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 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 Administrator and the Employer and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Administrator by the Employer, and any and all statements made to the Employer by the 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 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 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 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 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 Administrator and Providers shall administer and render services under the Plan insofar as practical, and according to their best judgment; but the 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 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 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 an 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

Applicability

This provision applies when you have health care coverage under more than one Plan. For the purposes of this provision, "Plan" is defined below.

If this provision applies, the Order of Benefit Determination Rules specify whether the benefits of this Plan are determined before or after those of another Plan. The benefits of this Plan:

1. will not be reduced when, under the Order of Benefit Determination Rules, this Plan determines its benefits before another Plan; but
2. may be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The reduction is described under the heading “Effects on the Benefits of this Plan.”

Definitions

Plan - this Plan and any other arrangement providing health care or benefits for health care through:

1. group insurance or group-type coverage whether insured or uninsured. This includes prepayment group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. coverage under a governmental Plan or coverage required or provided by law except Medicare or Medicaid.
3. the medical benefits coverage in-group, group-type, and individual automobile “no-fault” and traditional automobile “fault” type contracts.
4. any other coverage which, as defined by the Employee Retirement Income Security Act of 1974, is a labor-management trustee Plan, a union welfare Plan, an employee organization Plan or an employee benefit organization.
5. any other coverage provided because of sponsorship by or membership in any other association, union, or similar organization.

“Plan” is not any of the following:

1. Individual or family coverage, including insurance contracts, subscriber contracts, coverage through health maintenance organizations or other prepayment group practice and individual practice plans which are not group coverage.
2. Group or group-type Hospital indemnity benefits of \$100.00 per day or less.
3. School accident-type coverage for grammar, high school, and college students for accidents only, including athletic injuries, either on a 24-hour basis or on a “to and from” school basis.

Primary Plan/Secondary Plan - the Order of Benefit Determination Rules state whether this Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When this Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Allowable Expense - a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. The item of expense covered in part by this Plan is subject to the Plan's Maximum Allowable Amount.

The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice or as specifically defined in this Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When the benefits are reduced under a Primary Plan because a Member does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, Precertification of admissions or services, and preferred Provider arrangements. Only benefit reductions based upon provisions similar to this one and which are contained in the primary Plan may be excluded from allowable expenses. This provision shall not be used by a Secondary Plan to refuse to pay benefits because a health maintenance organization (HMO) Member has elected to have health care services provided by a non-HMO provider and the HMO, pursuant to this Benefit Booklet, is not obligated to pay for providing those services.

Allowable Expense does not include any expenses incurred or claims made under the Prescription Drug program of this Plan.

Order of Benefit Determination Rules

When there is a basis for a claim under this Plan and another Plan, this Plan is a Secondary Plan, which has its benefits determined after those of the other Plan, unless:

1. the other Plan has rules coordinating its benefits with those of this Plan; and
2. both those rules and this Plan's rules require that this Plan's benefits be determined before those of the other Plan.

This Plan determines its order of benefits using the first of the following rules, which applies:

1. Non-Dependent/Dependent. The benefits of the Plan which covers the person as a Subscriber or Member, (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent, except that: if the person is also a Medicare beneficiary, and as a result of the rules established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

- a. Secondary to the Plan covering the person as a Dependent; and
- b. Primary to the Plan covering the person as other than a Dependent (e.g. a retired employee);

then the order of benefits is reversed so that the Plan covering the person as an employee, Member, subscriber or retiree is secondary and the other Plan is primary.

2. Dependent Child/Parents not Separated or Divorced. When this Plan and another Plan cover the same child as a Dependent of parents who are not separated or divorced:
 - a. the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but
 - b. if both parents have the same birthday, the benefits of the Plan, which covered one parent longer, are determined before those of the Plan, which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in a. immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

3. Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - a. First, the Plan of the parent with custody of the child;
 - b. Then, the Plan of the spouse of the parent with custody of the child; and
 - c. Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the Primary Plan has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent will be the Secondary Plan.

4. **Joint Custody.** If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the Order of Benefit Determination Rules outlined in paragraph 2.
5. **Active/Inactive Subscriber.** The benefits of a Plan, which covers a person as an employee who is neither laid off nor retired or as that employee's Dependent are determined before those of a Plan, which covers that person as a laid off or retired employee or as that employee's Dependent. If the other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule 5 is ignored. This rule does not supersede rule 1 above.
6. **Continuation Coverage.** If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:
 - a. First, the benefits of a Plan covering the person as a Subscriber or Member or as that person's Dependent;
 - b. Second, the benefits under the continuation coverage. If the other Plan does not have the rule described above and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
7. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the Plan, which covered the person longer are determined before those of the Plan, which covered that person for the shorter term.

Effect on this Plan's Benefits

When a Member is covered under two or more Plans which together pay more than the Allowable expense, the Plan will pay this Plan's benefits according to the Order of Benefit Determination Rules. This Plan's benefit payments will not be affected when it is primary. However, when this Plan is secondary under the Order of Benefit Determination Rules, benefits payable will be reduced, if necessary, so that combined benefits of all Plans covering you or your Dependent do not exceed the Plan's Maximum Allowable Amount for the Allowable Expense.

When this Plan is secondary, you will receive credit during the remainder of the calendar year for the amount by which your benefits are reduced. This credit will not be applied to the extent that would cause you to receive:

1. a combined benefit from all Plans greater than the Allowable Expense; or
2. more benefits during a calendar year than you would receive if there were no other coverage.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Right to Receive and Release Needed Information

Certain facts are needed to apply these rules. The Administrator, on behalf of the Employer, has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Administrator any facts it needs to pay the claim.

Facility of Payment

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

1. the persons it has paid or for whom it has paid;
2. insurance companies; or
3. other organizations.

The “amount of the payments made” includes the reasonable cash value of any benefit provided in the form of services.

Worker's Compensation

The benefits under the Plan are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to 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 Worker's 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 Plan benefits are paid as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

The Administrator, on behalf of the Employer, has the right to recover Plan payments made on your behalf from any party responsible for compensating you for your injuries. The following apply:

- The Administrator, on behalf of the Employer, has the first priority for the full amount of benefits they have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable the Administrator, on behalf of the Employer, to exercise their rights and do nothing to prejudice them.
- The Administrator, on behalf of the Employer, has the right to take whatever legal action they see fit against any 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 Administrator's subrogation claim and any claim still held by you. The Administrator'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 Administrator, on behalf of the Employer, is not responsible for any attorney fees, other expenses, or costs without its prior written consent. The Administrator, on behalf of the Employer, further agrees that the “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Administrator, on behalf of the Employer.

Reimbursement

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

- You must reimburse the Administrator, on behalf of the Employer, to the extent of ~~Plan~~ benefits the Administrator, on behalf of the Employer, paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, the Administrator, on behalf of the Employer, shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for the Administrator, on behalf of the Employer, 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 Administrator, on behalf of the Employer, immediately upon your receipt of the Recovery. You must reimburse the Administrator, on behalf of the Employer, 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 Administrator, on behalf of the Employer.
- If you fail to repay the Administrator, on behalf of the Employer, the Administrator, on behalf of the Employer, shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Administrator, on behalf of the Employer, has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:
 1. The amount the Administrator, on behalf of the Employer, paid on your behalf is not repaid or otherwise recovered by the Administrator, on behalf of the Employer; or
 2. You fail to cooperate.
- In the event that you fail to disclose to the Administrator and/or the Employer the amount of your settlement, the Administrator, on behalf of the Employer, shall be entitled to deduct the amount of their lien from any future benefit under the Plan.

- The Administrator, on behalf of the Employer, shall also be entitled to recover any of the unsatisfied portions of the amount they have paid or the amount of your settlement, whichever is less, directly from the Providers to whom the Administrator, on behalf of the Employer, has made payments. In such a circumstance, it may then be your obligation to pay the Provider the full-billed amount, and the Administrator, on behalf of the Employer, would not have any obligation to pay the Provider.
- The Administrator, on behalf of the Employer, 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 or make you whole.

Your Duties

- You must notify the Administrator, on behalf of the Employer, 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 Administrator in the investigation, settlement, and protection of the Plan's rights.
- You must not do anything to prejudice the rights of the Administrator, on behalf of the Employer.
- You must send the Administrator, on behalf of the Employer, 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 Administrator, on behalf of the Employer, if you retain an attorney or if a lawsuit is filed on your behalf.

Right of Recovery

Whenever payment has been made in error, the Administrator, on behalf of the Employer, will have the right to recover such payment from you or, if applicable, the Provider. The 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 Administrator, on behalf of the Employer, has oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. The 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 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 Administrator, on behalf of the Employer, will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The 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-Administrator)

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

The Employer is fiduciary agent of the Member. The Administrator's notice to the Employer will constitute effective notice to the Member. It is the Employer's duty to notify the Administrator of eligibility data in a timely manner. The Administrator is not responsible for payment of Covered Services of Members if the Employer fails to provide the 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 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 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 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 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 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 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 Administrator. Please refer to your Identification Card for the Administrator's address and telephone number.

A complaint is an expression of dissatisfaction that can often be resolved by an explanation from the 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 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 Administrator for review in accordance with the procedures set forth below.

Administrator Appeals

An appeal is a request from you for the Administrator to change a previous determination made. An initial determination by the Administrator can be appealed for further review by the Administrator at two subsequent levels known as “Level 1” and “Level 2” appeals. The 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 Administrator must obtain a signed Designation of Representation form from you before the 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 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 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 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 7094; Indianapolis, IN 46207-7094, 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 Administrator.

If you are appealing an adverse pre-authorization decision or the denial of any prior approval required by the Plan, the 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 Administrator receives your Level 1 appeal request. If more information is needed to make a decision on your appeal, the 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 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 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 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 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 5 business days in writing by the 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 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 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 Administrator. After the appeal panel makes a decision you will be notified within 5 business days in writing by the 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 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 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 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 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 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 Administrator are exhausted. In a case of urgently needed care, the 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 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.

This Notice is provided by the following companies:



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