Anthem BlueCross BlueShield

*You've made a good decision in choosing Dental Blue®*

# *Shaker Heights City School District*

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**1/1/2021**

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*Administered by Community Insurance Company*

# Your Dental Benefit Booklet

# Dental Benefit Booklet

Dental Blue® Complete

Administered by

Community Insurance Company

**Important: This is not an insured benefit plan. The benefits described in this Benefit Booklet or any rider or amendments hereto are funded by the Employer who is responsible for their payment. Community Insurance Company dba Anthem Blue Cross and Blue Shield provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.**

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# 1 BENEFIT BOOKLET

Welcome to Anthem Blue Cross and Blue Shield! This Benefit Booklet has been prepared by the Administrator, on behalf of the Employer, to help explain your dental care benefits. 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.

The coverage described in this Benefit Booklet is based upon the conditions of the Administrative Services Agreement issued to your Employer, and is based upon the benefit plan that your Employer chose for you. The Administrative Services Agreement, this Benefit Booklet and any endorsements, amendments or riders attached, form the Administrative Services Agreement under which Covered Services are available under your dental care benefits.

This Benefit Booklet should be 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 coverage.

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. The Benefit Booklet also contains exclusions.

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

## Contents

# 2 SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the Deductibles, Coinsurance and other limits when you receive Covered Services from a Provider. Please refer to the Covered Services section of this Benefit Booklet for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of this Benefit Booklet including any attachments or riders. This Schedule of Benefits lists the Member's responsibility for Covered Services.

| | | |
|---|---|---|
| **Benefit Period** | Calendar Year | |
| **Dependent Age Limit** | To the end of the month in which the child attains age 26 | |
| **Dental Benefit Maximums** | | |
| Benefit Period Maximum (combined for Network and Non-Network Dentists) | $1,500 per Member | |
| Orthodontic Services Lifetime Maximum (combined for Network and Non-Network Dentists) | $1,500 per Member | |
| **Dental Deductible** | | |
| Per Member | $50 Network | $50 Non-Network |

**Exception**: The Deductible applies to Prosthodontic and Orthodontic services only.

**Dental Covered Services**
After the Plan subtracts the Dental Deductible from the total amount of the Maximum Allowed Amount, you will pay benefits for Covered Services at the percentage or applicable amount noted below.

| | **Network Dentist** | **Non-Network Dentist** |
|---|---|---|
| **Diagnostic and Preventive Services** (Not subject to the Deductible) | Dental Blue 100: No Coinsurance up to the Maximum Allowed Amount<br><br>Dental Blue 200: No Coinsurance up to the Maximum Allowed Amount<br>Dental Blue 300: No Coinsurance up to the Maximum Allowed Amount | No Coinsurance up to the Maximum Allowed Amount. You are responsible for any charges that exceed the Maximum Allowed Amount. |

| | | | |
|---|---|---|---|
| **Minor Restorative Services** (Not subject to the Deductible) | Dental Blue 100: | 15% Coinsurance | 15% Coinsurance, You are responsible for any charges that exceed the Maximum Allowed Amount |
| | Dental Blue 200: | 15% Coinsurance | |
| | Dental Blue 300: | 15% Coinsurance | |
| **Oral Surgery Services** (Not subject to the Deductible) | Dental Blue 100: | 15% Coinsurance | 15% Coinsurance, You are responsible for any charges that exceed the Maximum Allowed Amount |
| | Dental Blue 200: | 15% Coinsurance | |
| | Dental Blue 300: | 15% Coinsurance | |
| **Endodontic Services** (Not subject to the Deductible) | Dental Blue 100: | 15% Coinsurance | 15% Coinsurance, You are responsible for any charges that exceed the Maximum Allowed Amount |
| | Dental Blue 200: | 15% Coinsurance | |
| | Dental Blue 300: | 15% Coinsurance | |
| **Periodontal Services** (Not subject to the Deductible) | Dental Blue 100: | 15% Coinsurance | 15% Coinsurance, You are responsible for any charges that exceed the Maximum Allowed Amount |
| | Dental Blue 200: | 15% Coinsurance | |
| | Dental Blue 300: | 15% Coinsurance | |
| **Prosthodontic Services** | Dental Blue 100: | 20% Coinsurance | 20% Coinsurance, You are responsible for any charges that exceed the Maximum Allowed Amount |
| | Dental Blue 200: | 20% Coinsurance | |
| | Dental Blue 300: | 20% Coinsurance | |

| | | | |
|---|---|---|---|
| **Orthodontic Services** | Dental Blue 100: surance | 50% Coin- | 50% Coinsurance, You are responsible for any charges that exceed the Maximum Allowed Amount |
| | Dental Blue 200: surance | 50% Coin- | |
| | Dental Blue 300: surance | 50% Coin- | |

# 3 DEFINITIONS

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

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

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

**Administrative Services Agreement** - The agreement between the Administrator and the Employer regarding the administration of certain elements of the dental care benefits of the Employer's group dental plan.

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

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

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

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

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

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

**Cleft Lip and Palate** - For cosmetic treatment intended primarily to improve appearance but not to restore body function or correct deformity from disease, trauma, or prior therapeutic processes (includes treatment of cleft palate, anodontia and mandibular prognathicism, capping teeth to cover stains, laminate veneers, and shaping false teeth to make them look like the real teeth they replace.

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

**Covered Services** - Services or treatment as

described in the Benefit Booklet which are performed, prescribed, directed or authorized by a Dentist. To be considered Covered Services, services must be:

- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Plan is in force;
- Within the Maximum Allowed Amount;
- Medically Necessary;
- Not specifically excluded or limited by the Benefit Booklet; and
- Specifically included as a benefit within the Benefit Booklet.

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

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

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

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

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

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

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

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

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

**Fees** - The periodic charges which are required to be paid by you and/or the Employer to maintain benefits under the Plan.

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

- the availability of Providers;
- the handling or payment of claims for dental care services;
- matters pertaining to the contractual relationship between you and the Plan or the Employer and the Administrator.

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

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

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

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

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

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

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

**Non-Network Dentist** - A Dentist who has NOT entered into a contractual agreement with the Administrator, on behalf of the Employer, at the time services are rendered.

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

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

**Prosthesis (Prosthetics)** – A restorative service used to replace one or more missing or broken teeth and associated tooth structures. It includes all types of crowns, pontics, inlays, onlays, bridges, and dentures that are Covered Services.

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

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

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

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

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

# 4 ELIGIBILITY AND ENROLLMENT

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

by the Administrator, on behalf of the Employer.

**Your Eligibility requirements are described in general terms below. For more specific eligibility information, see your Human Resources or Benefits Department.**

## Eligibility

The following eligibility rules apply unless you are notified by the Employer.

### Subscriber

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

- Be an employee of the Employer, and:
- Be entitled to participate in the benefit Plan arranged by the Employer;
- Have satisfied any probationary or waiting period established by the Employer and be Actively At Work;
- Meet the eligibility criteria stated in the Administrative Services Agreement.

## Dependents

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

- The Subscriber's spouse as recognized under the laws of the state where the Subscriber lives.
- The Subscriber's or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the Employer has determined are covered under a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law).
- Children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law.

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

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

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

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

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under the Plan unless required by the laws of this state.

Coverage Effective Dates and enrollment requirements are described in the Administrative Services Agreement.

## College Student Medical Leave

The Plan will extend coverage for up to one year when a college student otherwise would lose eligibility, if a child takes a Medically Necessary leave of absence from a postsecondary educational

institution. Coverage will continue for up to one year of leave, unless Dependent coverage ends earlier under another Plan provision, such as the parent's termination of employment or the child's age exceeding the Plan's limit.

**Medically Necessary change in student status**. The extended coverage is available if a college student would otherwise lose coverage because a serious illness or injury requires a Medically Necessary leave of absence or a change in enrollment status (for example, a switch from full-time to part-time student status). The Plan must receive written certification from the child's Physician confirming the serious illness or injury and the Medical Necessity of the leave or change in status.

## Enrollment

### Initial Enrollment

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

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

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

## Newborn and Adopted Child Coverage

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

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

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

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

### Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child under the Plan, the Plan will permit your child to enroll at any time without regard to any Open Enrollment limits and shall provide the benefits of the Plan in accordance with the applicable requirements of such order. A child's coverage under this provision will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits. Any claims payable under the Plan will be paid, at the Plan's discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child,

custodial parent, or legal guardian. The Employer will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to the Administrator directly.

## Special Enrollment/Special Enrollees

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

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

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

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

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination. If the Plan receives an application to add your Dependent or an Eligible Person and Dependent more than 60 days after the loss of Medicaid/CHIP or of the eligibility determination, that person is only eligible for coverage as a Late Enrollee.

Application forms are available from the Employer.

## Late Enrollees

You are considered a Late Enrollee if you are an Eligible Person or Dependent who did not request enrollment for coverage:

- During the initial enrollment period; or
- During a Special Enrollment period; or
- As a newly eligible Dependent who failed to qualify during the Special Enrollment period and did not enroll within 31 days of the date you were first entitled to enroll.

However, you will not be enrolled for coverage with the Plan until the next Open Enrollment Period.

## Open Enrollment Period

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

## Notice of Changes

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

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible.

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

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

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

### Effective Date of Coverage

For information on your specific Effective Date of Coverage under the Plan, please see your human resources or benefits department. You can also contact the Administrator by calling the number located on the back of your Identification (ID) Card or by visiting www.anthem.com.

## 5 TERMINATION AND CONTINUATION

### Termination

Except as otherwise provided, your coverage may terminate in the following situations. The information provided below is general and the actual effective date of termination may vary based on your Employer's specific requirements:

- Subject to any applicable continuation or conversion requirements, if you cease to meet eligibility requirements as outlined in this Benefit Booklet, your coverage generally will terminate on the last day of the billing period. You must notify the Employer immediately if you cease to meet the eligibility requirements. You shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you engage in fraudulent conduct or furnish the Plan fraudulent or misleading material information relating to claims or application for coverage, then the Employer may terminate your coverage. Termination is generally effective 31 days after the notice of termination is mailed, except when indicated otherwise in the Schedule of Benefits. You are responsible to pay the Plan for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Fee paid for such services. The Employer will also terminate your Dependent's coverage, generally effective on the date your coverage was terminated.
- A Dependent's coverage will generally terminate at the end of the billing period in which notice was received by the Administrator that the person no longer meets the definition of Dependent, except when indicated otherwise in the Schedule of Benefits.
- If coverage is through an association, coverage will generally terminate on the date membership in the association ends.
- If you elect coverage under another carrier's dental benefit plan or under any other non-Anthem plan which is offered by, through, or in connection with the Employer as an option instead of this Plan, then coverage for you and your Dependents will generally terminate at the end of the billing period for which Fees have been paid.
- If you fail to pay or fail to make satisfactory arrangements to pay any amount due to the Plan or Participating Providers (including the failure to pay required Deductibles and/or Copayments), the Employer may terminate your coverage and may also

terminate the coverage of all your Dependents, generally effective immediately upon their written notice to you.

- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon written notice. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse the Plan for the Maximum Allowable Amount for services received through such misuse.

## Removal of Members

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

Note: Members can only be removed during Open Enrollment or if you experience a qualifying life event.

## Continuation

### Federal Continuation of Coverage (COBRA)

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

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

#### COBRA Continuation Coverage

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

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-Subscriber dies;
- The parent-Subscriber's hours of employment are reduced;
- The parent-Subscriber's employment ends for any reason other than his or her gross misconduct;
- The parent-Subscriber becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Employer's dental plan as a "Dependent child."

#### If Your Employer Offers Retirement Coverage

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

#### When is COBRA Coverage Available

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

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

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

#### How is COBRA Coverage Provided

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

#### COBRA continuation coverage is a temporary continuation of coverage.

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

months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

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

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

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

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

#### If You Have Questions

Questions concerning your Employer's dental plan and your COBRA continuation coverage rights should be addressed to the Employer. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting Employer dental plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

### Continuation of Coverage Due To Military Service

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

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

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

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

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

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

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

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

## Family and Medical Leave Act of 1993

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

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

# 6 DENTAL PROVIDERS

You do not have to select a particular Dentist to receive dental benefits. You have the freedom to choose what Dentist you want to utilize to access Covered Services. **However, the Maximum Allowed Amount may vary depending upon whether the Dentist is a Network Dentist (Dental Blue 100, Dental Blue 200, Dental Blue 300) or a Non-Network Dentist.**

**Network Dentists**. The Administrator have established a network of various types of Network Dentists. These Dentists are called "Network Dentists" because they have agreed to participate in the Administrator's contracted Preferred Provider Organization (PPO) network(s). Network Dentists have agreed to a rate they will accept for Covered Services.

**To find a Network Dentist, please access the Administrator's web site at www.anthem.com or call the Administrator's Customer Service Department at (800) 627-0004.**

### Non-Network Dentists

Non-Network Dentists are Dentists who have not signed any contract with the Administrator and are not in any of the Administrator's networks. They have not agreed to the Maximum Allowed Amount and other provisions of a Preferred Provider Organization contract. The amount of benefits payable under this Plan will be different for Non-Network Dentists than for Network Dentists.

# 7 YOUR DENTAL BENEFITS

The Plan will pay for Covered Services you incur while covered under this Plan, subject to all terms, conditions, limitations and exclusions specified in this Benefit Booklet.

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

## DENTAL DEDUCTIBLES

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

**Member Dental Deductible**. Each Benefit Period, you will be responsible for satisfying the Dental Deductible before the Plan begins to pay benefits under the Plan.

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

**Dental Deductible Carryover Provision**. If your Dental Deductible is not met in a given Benefit Period, the Maximum Allowed Amount incurred during the last three (3) months of the Benefit Period and applied toward the Dental Deductible for that Benefit Period will also be applied to your Dental Deductible for the next Benefit Period. If your Dental Deductible is satisfied in a given Benefit Period, the Plan will not carry over any amount applied toward that Benefit Period Dental Deductible to the next Benefit Period's Dental Deductible.

## DENTAL BENEFIT MAXIMUMS

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

## HOW DENTAL BENEFITS ARE PAID

**Network Dentists**. Your dental benefits will vary depending on your choice of Dentists as outlined in the Schedule of Benefits. You will normally receive the greatest level of benefits available for Covered Services under this plan when you seek treatment from a Dental Blue 100 Network Dentist.

Please refer to your Identification Card to verify that you are a member of Dental Blue 100/200/300. If you are uncertain which Network Dentists will provide you with the lowest out-of-pocket expense, please contact customer service at the toll-free number indicated on your Identification Card or visit online at www.anthem.com.

**Non-Network Dentists**. Your Coinsurance will be based on the Non-Network Dentist percentages if Covered Services are provided by a Non-Network Dentist. A Non-Network Dentist can charge their usual billed charges for services rendered.

**SUMMARY OF COSTS**

**If you receive treatment from a Dental Blue 100, Dental Blue 200, or Dental Blue 300 Network Dentist**:

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

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

- Coinsurance will be based on the Non-Network Dentist percentages listed in the Schedule of Benefits.
- You are responsible for your Coinsurance, Dental Deductibles, non-Covered Services, and any amounts over the dental benefit maximums as outlined in the Schedule of Benefits PLUS any amount which exceeds the Maximum Allowable Amount.

# 8 DENTAL UTILIZATION REVIEW

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

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

## Pre-Treatment Review

You may have a pre-treatment review done before you receive benefits. Pre-treatment review is not a prior authorization for services but is a system that allows you and your Dentist to know, in advance, what the estimated benefits payable would be under this Plan for a proposed course of treatment. The actual benefits you receive under the plan will be determined once a claim for services has been received and may vary from the estimated benefits based upon the actual services received as well as the benefit coverage in effect on the date(s) of services.

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

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

## Retrospective Review

Retrospective review means a Medical Necessity review that is conducted after dental care services have been provided. A claim review includes, but

is not limited to, an evaluation of reimbursement levels, accuracy of documentation, accuracy of coding and adjudication of payment.

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

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

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

## 9 DENTAL CONDITIONS OF SERVICE

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

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

## 10 COVERED SERVICES

Dental care services must be performed and billed by a Provider acting within the scope of his or her license. If general anesthesia is rendered in connection with Periodontic or Restorative Services, then it is paid at the same percentage as the Periodontic or Restoration Services. 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 special treatment schedules and benefit maximums.

### Pretreatment Estimates and Treatment Plans

A written Pretreatment Estimate is available from the Administrator or the Subcontractor. Either you or your Provider may submit a request for a Pre-Treatment Estimate. In order for the Administrator or the Subcontractor 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 Administrator or the Subcontractor 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. Note: 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.

## Diagnostic and Preventive Services

- Initial and periodic oral examinations, supplementary bitewing x-rays, prophylaxis (cleaning of teeth), and topical fluoride application (twice for each service in any 12 consecutive months) NOTE: If both bitewing and Panorex X-rays are done, benefits are paid on the basis of full-mouth X-rays under Maintenance Services;
- Emergency treatment for pain and emergency oral examinations, this does not count towards the limit of twice for each service in any 12 consecutive months;
- Space maintainers that replace prematurely lost teeth for children under age 19.

## Primary Services

### Maintenance Services

- X-ray examinations, including full mouth (one set each 36 consecutive months);
- Management of acute infections and oral lesions (wounds or sores in the mouth);
- Routine filings (to restore diseased or accidentally broken teeth). Fillings may be made of amalgam, silicate, acrylic, synthetic, porcelain, or composite materials;
- Endodontics (procedures to prevent and treat diseases of the dental pulp), including root canal treatment, direct pulp capping, and pulpotomy;
- Repair of removable dentures;
- Recementing of crowns, inlays, onlays and bridges;
- Denture adjustments and relining at least six months after their installation (once each 36 consecutive months);
- Fixed bridge repairs;
- Pit and fissure sealants on unrestored and non-decayed areas of posterior teeth are covered only for children under age 19 (once each 36 consecutive months).

## Oral Surgical Services

- Tooth extractions;
- Apicoectomy (surgical removal of the apex or tip of the tooth root);
- Removal of a root of multi-rooted tooth and its related crown portion, or a root resection;
- General anesthesia in connection with the above services.

## Periodontic Services (diagnosis and treatment of gum disease)

- Gingivectomy (removal of gum tissue around the necks of the teeth);
- Gingivoplasty (the recontouring of gum tissue);
- Gingival curettage (removal of diseased gum tissue);
- Osseous surgery (surgery performed on the alveolar bone, including flap entry and closure);
- Mucogingivoplastic surgery;
- Periodontal scaling and root planning.

## Prosthetic and Complex Restorative Services

### Complex Restorative Services

- Inlays, onlays, and crown restorations for diseased or accidentally broken teeth. Crown restorations include post and core and/or crown build-up when appropriate. These restorations are covered only if regular fillings would not restore your teeth adequately (not part of a bridge);
- Porcelain or other veneer crowns and pontics placed on the molars will be paid the same as a full cast gold crown or cast gold pontic;
- Replacements for inlays, onlays, and crown restorations installed while this coverage was in effect but only if it cannot be repaired and is at least 5 years old.

### Prosthetic Services

- Initial installation of dentures (full or partial) and the initial installation of bridges. Bridgework means a false tooth or false teeth fixed at each end to existing teeth;
- Replacements for dentures or bridgework installed while this coverage was in effect or the addition of false teeth to these appliances but only if one of the following conditions exits:

  1. A denture or bridgework cannot be repaired and the appliance is at least 5 years old;
  2. The existing denture is an immediate temporary denture which must be replaced within 1 year;
  3. You have had more teeth extracted.

### Missing Tooth Benefit

Removable dentures (full or partials) or fixed (bridges) for the replacement of teeth (or tooth) lost prior to the Member's Effective Date under this Benefit Booklet are covered.

## Orthodontic Services

**To determine if your coverage includes orthodontic services, check your Schedule of Benefits.**

Orthodontic services are covered to correct malocclusion. Orthodontic services include office records, comprehensive full banding of the permanent dentition, the initial retention appliance and office visits for retention, cephalometric file (included in records fee) and post-treatment stabilization.

Payment for orthodontic services will be made over the course of treatment and prorated.

When oral exams, x-rays, surgery, extractions, and other Covered Services are rendered in connection with orthodontic treatment, those services are considered to be part of the orthodontic course of treatment and are paid in accordance with the Scheduled Benefits for orthodontic services and counted toward that lifetime maximum. If your Schedule of Benefits excludes orthodontic services, then any of the above considered to be part of that course of orthodontic treatment are also excluded.

The lifetime maximum for orthodontic services is shown in the Schedule of Benefits. **Orthodontia is only covered for those Members shown in the Schedule of Benefits.**

When a Member is already receiving active or retention treatment on their Effective Date, the prorated amount for the number of months of treatment provided before the Effective Date will be subtracted from the benefit payable.

# 11 NON-COVERED SERVICES/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. While the Administrator is allowed by the Employer to determine whether services or supplies are not covered under the Plan, the Employer is the final authority.

The Plan does not provide benefits for services or supplies:

1. Which are not prescribed by or performed by or upon the direction of a Physician or other Provider;
2. Received from other than a Provider;
3. Procedures not yet recognized by the American Dental Association as indicated with a specific procedure code designation.
4. 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;
5. To the extent that they are available as benefits through any governmental unit (except Medicaid), unless otherwise required by law or regulation. The payment of benefits under this Certificate will be coordinated with such governmental units to the extent required under existing state or Federal laws;

6. For illness or injury that occurs as a result of any act of war, declared or undeclared;
7. For which you have no legal obligation to pay in the absence of this or like coverage;
8. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group;
9. Received from a member of your immediate family, (parent, child, spouse, sister, brother, or self);
10. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident;
11. For telephone consultations, missed appointments, completion of claim forms, or medical records;
12. For which benefits are payable under Medicare Part A and/or Medicare Part B or would have been payable if a Covered Person had applied for Part A and/or Part B;
13. In excess of the Maximum Allowable Amount;
14. For court ordered testing or care, unless authorized by the Administrator, on behalf of the Employer;
15. For congenital or developmental malformation;
16. For cosmetic treatment intended primarily to improve appearance but not to restore body function or correct deformity from disease, trauma, or prior therapeutic processes (includes treatment of cleft palate, anodontia and mandibular prognathicism, capping teeth to cover stains, laminate veneers, and shaping false teeth to make them look like the real teeth they replace;
17. Rendered or furnished prior to the Effective Date of this Benefit Booklet or subsequent to its termination;
18. For oral hygiene and convenience items;
19. For gold foil restorations;
20. Resulting from loss or theft of an artificial denture or orthodontia appliance;
21. For visits at home, or in a nursing home, or in a hospital escept for visits in connection with oral surgery and emergency care;
22. For restorations or appliances to increase vertical dimension or to restore or correct the occlusion, or Temporal Mandibular Joint (TMJ) disorder or dysfunction;
23. For periodontal splinting and implantology, or extra oral grafts;
24. For personalized restorations and specialized techniques in constructing dentures or bridges;
25. For permanent crowns for patients under age 16;
26. For prosthetic devices or crowns installed after coverage terminates, even if the impressions were taken while coverage was still in effect;
27. For prosthetic devices or crowns installed after coverage is effective, unless impressions were taken after this coverage became effective;
28. To the extent that they are covered by a basic benefit health or major medical health plan;

29. For which a satisfactory result cannot be obtained in the professional judgement of the attending Dentist;
30. Excessive charges resulting from repetition of services or replacement appliances when not necessary because you transferred from one Dentist to another during a course of treatment, you missed an appointment; services were rendered by more than one Dentist; or an example is Restoration of the same tooth surface within 6 months;
31. To stabilize the teeth in their supporting structures; examples include implantology and periodontal splinting;
32. To correct a congenital malformation (one you were born with);
33. A plaque control program, oral hygiene or dietary instruction;
34. A duplicate (space) prosthetic device or appliance;
35. For local or partial anesthesia (analgesia) including intravenous sedation;
36. For services or supplies not specifically listed in this Benefit Booklet.

# 12 HOW MAXIMUM ALLOWED AMOUNT IS DETERMINED

## General

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

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

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

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

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

## Provider Network Status

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

## Network Dentist

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

## Non-Network Dentist

Dentists who have not signed any contract with Us and are not in any of Our networks are Non-Network Dentists.

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

1. An amount based on Our managed care fee schedules used with Network Providers, which We reserve the right to modify from time to time; or
2. An amount based on information provided by a third party vendor which may reflect comparable Providers' fees and costs to deliver care; or
3. An amount negotiated by Us or a third party vendor which has been agreed to by the Network Provider; or
4. An amount equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

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

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

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

## Member Cost Share

For certain Covered Services and depending on your plan design, you may be required to pay a part of the Maximum Allowed Amount as your

cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

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

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

# 13 CLAIMS PAYMENT

## Payment of Benefits

You authorize the Plan to make payments directly to Providers for Covered Services. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under the Employer's Plan), or that person's custodial parent or designated representative. Any payments made by the Plan will discharge the Plan's obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA.

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

## Notice of Claim

The Plan is not liable, unless the Administrator receives written notice that Covered Services have been given to you. The notice must be given to the Administrator, on behalf of the Employer, 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.

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

Failure to give the Administrator notice within 90 days will not reduce any benefit if you show that the notice was given as soon as

reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

## Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for claim forms to the Administrator, or contact customer service and ask for claim forms to be sent to you. If you do not receive the claim forms, written notice of services rendered may be submitted to the Administrator 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 Provider's signature.

## Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

## Explanation of Benefits

After you receive dental care, you will often receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from the Plan 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 action after the Appeals Process.

# 14 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 Subscriber and Dependents, if any, constitute the entire agreement between the Plan and the Employer and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by the Employer and any and all statements made to the Employer by the Plan 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 a person authorized to sign on behalf of the Employer.

## Relationship of Parties (Plan - Network Dentists)

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

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

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

## Not Liable for Provider Acts or Omissions

The Plan is 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 Plan based on the actions of a Provider of dental care, services or supplies.

## Identification Card

Your Identification Card lists the PPO network applicable to you. When you receive care from a Network or Non-Network Dentist, you must show your Identification Card. Possession of an Identification Card confers no right to services or other benefits under 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. If you receive services or other benefits to which you are not then entitled under the provisions of this Benefit Booklet you will be responsible for the actual cost of such services or benefits.

## Circumstances Beyond the Control of the Plan

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

## 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 Dental 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

This Coordination of Benefits ("COB") provision applies when a person has dental care coverage under more than one **Plan**. **Plan** is defined below.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**.

The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** do not exceed 100% of the total **Allowable expense**.

### Definitions

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

    1. **Plan** includes: group and non group insurance contracts, health insuring corporation ("HIC") contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
    2. **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

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

- The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has dental care coverage under more than one **Plan**. When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

- **Allowable expense** is a dental care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an **Allowable expense**.

  The following are examples of expenses that are not **Allowable expenses**:

  1. If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.
  2. If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.
  3. If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**.

     However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.
  4. The amount of any benefit reduction by the **Primary plan** because a Member has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of dental services, and preferred provider arrangements.

- **Closed panel plan** is a **Plan** that provides dental care benefits to Members primarily in the form of services through a panel of providers which have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

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

## Order of Benefit Determination Rules

When a person is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

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

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

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

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

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

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

(2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or
- If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.
- However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), the Administrator will follow the rules of that plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

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

(ii) If a court decree states that both parents are responsible for the dependent child's dental care expenses or dental care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental care expenses or dental care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's dental care expenses or dental care coverage, the order of benefits for the child are as follows:

- The **Plan** covering the **Custodial parent**;
- The **Plan** covering the spouse of the **Custodial parent**;
- The **Plan** covering the **non-custodial parent**; and then
- The **Plan** covering the spouse of the **non-custodial parent**.

(c) For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active employee or retired or laid-off employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

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

## Effect On The Benefits Of This Plan

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

deductible in the absence of other dental care coverage.

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

### Right to Receive and Release Needed Information

Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits payable under **This plan** and other **Plans**. The Administrator may get the facts it needs from them or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. The 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 apply those rules and determine benefits payable.

### Facility of Payment

A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, the **Plan** may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. 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 payments made by the Plan is more than the Plan should have paid under this **COB** provision, the Administrator may recover the excess from one or more of the persons the Plan paid or for whom the Plan had paid, or any other person or organization that may be responsible for the benefits or services provided for the Member. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

### Coordination Disputes

If you believe that the Plan has not paid a claim properly, you should attempt to resolve the problem by contacting the Administrator. Follow the steps described in the "Grievance and Appeal Procedures" section of this Benefit Booklet.

### 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 Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

## Other Government Programs

The benefits under the Plan shall not duplicate any benefits that Members are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require the Plan to be the primary payor. If the Plan has duplicated such benefits, all money paid by such programs to Members for services they have or are receiving, shall be paid by or on behalf of the Member to the Plan.

## Subrogation and Reimbursement

These provisions apply when the Plan pays benefits as a result of injuries or illness you

sustained and you have a right to a Recovery or have received a Recovery.

## Subrogation

The Plan has the right to recover payments it makes on your behalf from any party responsible for compensating you for your injuries. The following apply:

- The Plan has first priority for the full amount of benefits it has 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 Plan to exercise the Plan's rights and do nothing to prejudice them.
- The Plan has the right to take whatever legal action it sees 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 Plan's subrogation claim and any claim still held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, other expenses or costs you incur without the Plan's prior written consent. The Plan further agree that the "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

## Reimbursement

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

- You must reimburse the Plan to the extent of benefits the Plan paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, the Plan shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the Recovery. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.
- If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:
    1. The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or
    2. You fail to cooperate.
- In the event that you fail to disclose to the Plan the amount of your settlement, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your settlement, whichever is less, directly from the Providers to whom the Plan has made payments. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Plan would not have any obligation to pay the Provider.

- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

### Your Duties

- You must notify the Plan promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights.
- You must not do anything to prejudice the Plan's rights.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.

## Right of Recovery

Whenever payment has been made in error, the Plan will have the right to recover such payment from you or, if applicable, the Provider. In the event the Plan recovers a payment made in error from the Provider, except in cases of fraud, the Plan will only recover such payment from the Provider during the 24 months after the date the Plan made the payment on a claim submitted by the Provider. The Plan 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-Plan)

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

The Employer is responsible for passing information to the Member. For example, if the Plan gives notice to the Employer, it is the Employer's responsibility to pass that information to the Member. The Employer is also responsible for passing eligibility data to the Plan in a timely manner. If the Employer does not provide the Plan with timely enrollment and termination information, the Plan is not responsible for the payment of Covered Services for Members.

## Conformity with Law

Any provision of this Plan which is in conflict with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

## Clerical Error

Clerical error, whether of the Administrator or the Plan, in keeping any record pertaining to this coverage will not invalidate coverage otherwise

validly in force or continue coverage otherwise validly terminated.

## Policies and Procedures

The Employer is able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules and interpretations.

## Waiver

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

## 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

The Administrator 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 Grievances 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. The Administrator has complete discretion to interpret the Benefit Booklet. The Administrator's determination shall be final and conclusive and may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental Procedures, and whether charges are consistent with the Plan's Maximum Allowed Amount. A Member may utilize all applicable Grievance & Appeals procedures.

## Anthem Blue Cross and Blue Shield Note

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

# 15 GRIEVANCE AND APPEAL PROCEDURES

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

## Grievances

If a Member has a Grievance about any aspect of the Administrator's service, such as the processing of a dental claim, dental treatment or services rendered the Member should contact the Administrator's customer service department. The Administrator will acknowledge receipt of the Grievance and provide a resolution within the state's specified Grievance resolution time frames. A Member may file a verbal Grievance through the Administrator's toll-free number or submit a written Grievance to the address listed below. If after working with the Administrator the Member is not satisfied with the resolution of their Grievance, the Member may file an Appeal as explained in the Appeals section below:

Anthem Blue Cross and Blue Shield
Grievance Department
P.O. Box 659471
San Antonio, TX 78265-9471
1-800-627-0004

## Appeals

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

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

Anthem Blue Cross and Blue Shield
Appeals Department
P.O. Box 659471
San Antonio, TX 78265-9471
1-800-627-0004

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

The Grievance and Appeals process is governed by laws and regulations, and may be modified from time to time by the Administrator, in agreement with the Employer, as those laws may require.

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

## Expedited Appeal and/or Expedited Independent External Review

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

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

## Grievances and Appeals by Members of ERISA Plans

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

## Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

## Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة.
(TTY/TDD: 711)

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French
Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Navajo
Bee ná ahóót'i' t'áá ni nizaad k'ehjí niká a'doowoł t'áá jiik'e. Naaltsoos bee atah nilínígíí bee néého'dólzingo nanitinígíí béésh bee hane'i bikáá' áaji' hodíílnih. Naaltsoos bee atah nilínígíí bee néého'dólzingo nanitinígíí béésh bee hane'i bikáá' áaji' hodíílnih. (TTY/TDD: 711)

**It's important we treat you fairly**
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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.

Group Name: Shaker Heights City School District

Group Identification Number:

Subgroup Identification Number:

Mail to group.

Shaker Heights City School District