



Dental Certificate of Coverage

Abbington Management Corp
Group Number DD1045

Anthem Dental Value Complete Dental Program

NOTICE: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Read all of the rules very carefully, including the Coordination of Benefits section, and compare them with the rules of any other plan that covers you or your family.

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DeCare Dental Health International, L.L.C. is a separate company that provides dental benefit management services on behalf of Anthem Blue Cross and Blue Shield.

DENTAL CERTIFICATE OF COVERAGE

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

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

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

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

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

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

Community Insurance Company
1351 William H. Taft Road
Cincinnati, OH 45206

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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.

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

Benefit Waiting Period - The period of continuous coverage under this Certificate that a Member must complete following his or her Effective Date before dental benefits are payable for Covered Services. No payment will be made for expenses incurred during the Benefit Waiting Period indicated in the Summary of Benefits.

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

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.

Coverage Year - The period of time that We pay benefits for Covered Services. The Coverage Year is listed in the Summary of Benefits. If your coverage ends earlier, the Coverage Year ends at the same time.

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

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

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

Deductible - The dollar amount of Covered Services listed in the Summary of Benefits for which you are responsible before We start to pay for Covered Services each Coverage Year.

Dental Service, Dental Services, Dental Procedure and Dental Procedures - The providing of dental care or treatment by a Dentist to a Member under this Certificate, provided that such care or treatment is recognized by Anthem as a generally accepted form of care or treatment according to prevailing standards of dental practice.

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

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

Effective Date - The date that a Subscriber's coverage begins under this Certificate. A Dependent's coverage also begins on the Subscriber's Effective Date.

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

Group Dental Contract (or Contract) - The Contract between the Plan and the Group. It includes this Certificate, your application, any supplemental application or change form, and any additional legal terms added by Us to the original Contract. The final interpretation of any specific provision contained in this Certificate is governed by the Group Dental Contract.

Group or Group Subscriber - The employer, or other organization, that has entered into a Group Dental Contract with the Plan.

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

Maximum Allowed Amount - The maximum amount of reimbursement Anthem will pay for services provided by a Provider to a Member. You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Coinsurance. There may be different levels of reimbursement for the Maximum Allowed Amount depending upon whether you elect to receive services from a Participating Dentist or a Non-Participating Dentist. The Maximum Allowed Amount will always be the lesser of the maximum amount of reimbursement established by Anthem or the Provider's billed charges.

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

Non-Participating Dentist - A Dentist who has NOT signed a written provider service agreement agreeing to service the program identified in this Certificate. Anthem will reimburse Non-Participating Dentists according to the Maximum Allowed Amount for Non-Participating Dentists, also referred to in this Certificate as the Table of Allowances. The Table of Allowances may be different from the Maximum Allowed Amount reimbursed to Participating Dentists.

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

Participating Dentist - A Dentist who has signed a written provider service agreement agreeing to service the program identified in this Certificate. The Dentist has agreed to accept Anthem's Schedule of Maximum Allowable Charges as payment in full for dental care covered under this Certificate.

Plan (or We, Us, Our) - Anthem Blue Cross and Blue Shield. Also referred to as "Anthem".

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

Pretreatment Estimate - A request by a Member or Dentist to Anthem in advance of a Dental Service being provided to determine the Member's benefits, estimate the Maximum Allowed Amount, and estimate the amount of the Member's financial liability. A Pretreatment Estimate is not a guaranty of benefits or a guaranty of payment of benefits.

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.

Schedule of Maximum Allowable Charges - A schedule of Maximum Allowed Amounts established by Anthem for services rendered by Participating Dentists servicing this program.

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

Table of Allowances - A schedule of fixed dollar Maximum Allowed Amounts established by Anthem for services rendered by Non-Participating Dentists.

SUMMARY OF BENEFITS

The Summary 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 Certificate 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 Certificate including any attachments or riders.

Coverage Year	Calendar Year - A 12-month period starting January 1 – December 31 at 12:01 A.M., Eastern Time
Dependent Age Limit	To the end of the month in which the child attains age 26.
Benefit Waiting Period	There are no benefit waiting periods.

DENTAL BENEFIT MAXIMUMS

Dental Benefit Maximums (combined for Participating and Non-Participating Dentists)

Coverage Year Maximum \$750.00 per Member

Coverage Year Maximum. Your combined benefits are subject to the Coverage Year Maximum. We will not pay any benefit in excess of that amount during a Coverage Year.

DEDUCTIBLES

Deductibles do not apply to this Plan.

Dental Covered Services

After you have satisfied the Deductible, We will pay benefits for Covered Services at the percentage or applicable amount up to the Maximum Allowed Amount for each completed Dental Service. The Maximum Allowed Amount payable for each Dental Procedure is determined by Anthem, and there may be different levels of reimbursement for the Maximum Allowed Amount depending upon whether you elect to receive services from a Participating or a Non-Participating Dentist.

	Participating Dentist	Non-Participating Dentist
Diagnostic and Preventive Services	100%	100%
Basic Restorative Services	50%	50%
Endodontic Services	50%	50%
Periodontal Services	50%	50%
Oral Surgery Services	50%	50%
Major Restorative Services	50%	50%
Prosthodontic Services	50%	50%

ELIGIBILITY AND ENROLLMENT

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

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

Eligibility

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

Subscriber

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

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

Dependents

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

- The Subscriber's spouse. For information on spousal eligibility please contact the Group.
- The Subscriber's or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children, children placed for adoption, and children who the Group has determined are covered under a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.
- 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 also 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 Us 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, We may require that the Subscriber complete a "Dependency Affidavit"

and provide Us with a copy of any legal documents awarding guardianship of such child(ren) to the Subscriber. Temporary custody is not sufficient to establish eligibility under this Certificate.

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

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.

Coverage continues even if the plan changes. Dependent coverage will continue during the leave as if the child had maintained student eligibility. This requirement applies even if a Plan changes during the extended period of coverage.

Out of Service Area Dependent Child Coverage

Benefits for Covered Services will be provided for enrolled Dependent children who reside outside of the Service Area due to such children attending an out of Service Area educational institution or residing with the Subscriber's former spouse. Benefits are payable at the Network level and are limited to the Maximum Allowable Amount. Payment is subject to any Coinsurance, Copayment and/or Deductible. You may be responsible for any amount in excess of the Maximum Allowable Amount.

If you are eligible to enroll as a Member, you must enroll at the time agreed upon by the Plan. Otherwise, you may only enroll during the Open Enrollment period or during a Special Enrollment period, whichever is applicable.

Enrollment

Initial Enrollment

An Eligible Person can enroll for Single or Family Coverage by submitting an application to the Plan. The application must be received by the date stated on the Group Contract or the Plan's underwriting rules for initial application for enrollment. Coverage will be effective based on the waiting period chosen by the Group, and will not exceed 90 days.

If We do not receive the initial application by this date, the Eligible Person can only enroll for coverage during the Open Enrollment period or during a Special Enrollment period, whichever 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, whichever 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.

Continuous Coverage

If you were covered by the Group's prior carrier or plan immediately prior to the Group's enrollment with Anthem Blue Cross Blue Shield, with no break in coverage, then you will receive credit for any accrued Deductible and, if applicable and approved by Us, Out of Pocket amounts under that other plan. This does not apply to persons who were not covered by the prior carrier or plan on the day before the Group's coverage with Us began, or to persons who join the Group later.

If your Group moves from one Anthem Blue Cross Blue Shield plan to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately prior to enrolling in this product with no break in coverage, then you may receive credit for any accrued Deductible and Out of Pocket amounts, if applicable and approved by Us. Any maximums when applicable, will be carried over and charged against the maximums under this Certificate.

If your Group offers more than one Anthem product, and you change from one Anthem product to another with no break in coverage, you will receive credit for any accrued Deductible and, if applicable, Out of Pocket amounts and any maximums will be carried over and charged against maximums.

If your Group offers coverage through other products or carriers in addition to Anthem's, and you change products or carriers to enroll in this Anthem product with no break in coverage, you will receive credit for any accrued Deductible, Out of Pocket, and any maximums amounts.

This Section Does Not Apply To You If:

- Change from an individual Anthem Blue Cross Blue Shield policy to a group Anthem Blue Cross Blue Shield plan; or
- Change employers and both have Anthem Blue Cross Blue Shield coverage; or
- Are a new Member of the Group who joins the Group after the Group's initial enrollment with Us.

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 Group, or the Plan, a request to add the child under the Subscriber's Certificate. The request must be submitted within 31 days after the birth of the child. Failure to notify the Plan during this 31 day period will result in no coverage for the newborn beyond the first 31 days, except as permitted for a Late Enrollee.

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

Adding a Child due to Award of Legal Custody or Guardianship

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

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child under this Certificate, We will permit your child to enroll at any time without regard to any Open Enrollment limits and shall provide the benefits of this Certificate in

accordance with the applicable requirements of such order. A child's coverage under this provision will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits. Any claims payable under this Certificate will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Special Enrollment/Special Enrollees

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your other coverage ends (or within 60 days after Medicaid coverage ends) after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents in the Plan, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

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

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 We receive 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, we will not be able to enroll that person until the Group's next Open Enrollment.

Application forms are available from the Plan.

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 Group's next annual enrollment.

Open Enrollment means a period of time (at least 31 days prior to the Group's renewal date and 31 days following) which is held no less frequently than once in any 12 consecutive months.

Notice of Changes

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

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

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

A Member's coverage terminates as specified in the Termination section of this Certificate. 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.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender or age.

Effective Date of Coverage

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

Statements and Forms

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

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

Delivery of Documents

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

TERMINATION AND CONTINUATION

Except as otherwise provided, your coverage may terminate in the following situations. The information provided below is general and the actual effective date of termination may vary based on your Group's agreement with Us and your specific circumstances, such as whether Premium has been paid in full.

Termination of Coverage

Your coverage and that of your eligible Dependents ceases on the earliest of the following dates:

- a) On the date in which (1) you cease to be eligible; (2) your Dependent is no longer eligible as a Dependent under the Certificate.
- b) On the date the Certificate is terminated.
- c) On the date the Group terminates the Certificate by failure to pay the Premiums, except as a result of inadvertent error.
- d) The date contribution for coverage under the Certificate is not made when due.

For extended eligibility, see Continuation of Coverage.

Continuation of Coverage (COBRA)

Dental benefits may be continued should any of the following events occur, provided that at the time of occurrence this Certificate remains in effect and you or your spouse or your Dependent child is a Member under this Certificate:

QUALIFYING EVENT	WHO MAY CONTINUE	MAXIMUM CONTINUATION PERIOD
Employment ends, retirement, leave of absence, lay-off, or employee becomes ineligible (except gross misconduct dismissal)	Subscriber and Dependents	Earliest of: 1. 18 months, or 2. Enrollment in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Divorce, marriage dissolution, or legal separation	Former spouse and any Dependent children who lose coverage	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Death of Subscriber	Surviving spouse and Dependent children	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.

Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Dependents lose eligibility due to Subscriber's entitlement to Medicare	Spouse and Dependents	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Subscriber's total disability	Subscriber and Dependents	Earliest of: 1. 29 months, or 2. Date total disability ends, or 3. Enrollment date in other group coverage or Medicare.
Retirees of employer filing Chapter 11 bankruptcy (includes substantial reduction in coverage within 1 year of filing)	Retiree and Dependents	Earliest of: 1. Enrollment date in other group coverage, or 2. Death of retiree or Dependent electing COBRA.
Surviving Dependents of retiree on lifetime continuation due to the bankruptcy of the employer	Surviving spouse and Dependents	Earliest of: 1. 36 months following retiree's death, or 2. Enrollment date in other group coverage.

You or your eligible Dependents have 60 days from the date you lose coverage, due to one of the events described above, to inform the Group that you wish to continue coverage.

1. Choosing Continuation

If you lose coverage, your employer must notify you of the option to continue coverage within 14 days after employment ends. If coverage for your Dependent ends because of divorce, legal separation, or any other change in Dependent status, you or your covered Dependents must notify your employer within 60 days.

You or your covered Dependents must choose to continue coverage by notifying the employer in writing. You or your covered Dependents have 60 days to choose to continue, starting with the date of the notice of continuation or the date coverage ended, whichever is later. Failure to choose continuation within the required time period will make you or your covered Dependents ineligible to choose continuation at a later date. You or your covered Dependents have 45 days from the date of choosing continuation to pay the first continuation charges. After this initial grace period, you or your covered Dependents must pay charges monthly in advance to the employer to maintain coverage in force.

Charges for continuation are the group rate plus a two percent administration fee. All charges are paid directly to your employer. If you or your covered Dependents are totally disabled, charges for continuation are the group rate plus a two percent administration fee for the first 18 months. For months 19 through 29, the employer may charge the group rate plus a 50 percent administration fee.

2. Second qualifying event

If a second qualifying event occurs during continuation, a Dependent qualified beneficiary may be entitled to election rights of their own and an extended continuation period. This rule only applies when the initial qualifying event for continuation is the employee's termination of employment, retirement, leave of absence, layoff, or reduction of hours.

When a second qualifying event occurs such as the death of the former covered employee, the Dependent must notify the employer of the second event within 60 days after it occurs in order to continue coverage. In no event will the first and second period of continuation extend beyond the earlier of the date coverage would otherwise terminate or 36 months.

A qualified beneficiary is any individual covered under the health plan the day before the qualified event as well as a child who is born or placed for adoption with the covered employee during the period of continuation coverage.

3. Terminating Continuation of Coverage - COBRA

Continuation of Coverage - COBRA for you and your eligible Dependents, if selected, shall terminate on the last day of the month in which any of the following events first occur:

- a) The expiration of the specified period of time for which Continuation of Coverage - COBRA can be maintained; as mandated by applicable State or Federal law;
- b) This Certificate is terminated by the Group Subscriber;
- c) The Group Subscriber's or Member's failure to make the payment for the Member's Continuation of Coverage

Questions regarding Continuation of Coverage - COBRA should be directed to your employer. Your employer will explain the regulations, qualifications and procedures required when you continue coverage.

DENTAL PROVIDERS AND CLAIMS PAYMENT

You do not have to select a particular Dentist to receive dental benefits. You have the freedom to choose the Dentist you want for your dental care. However, your Dentist choice can make a difference in the benefits you receive and the amount you pay. You may have additional out-of-pocket costs if your Dentist is a Non-Participating Dentist. There may be differences in the payment amount compared with a Participating Dentist if your Dentist is a Non-Participating Dentist.

PAYMENTS ARE MADE BY ANTHEM ONLY WHEN THE COVERED DENTAL PROCEDURES HAVE BEEN COMPLETED. THE PLAN MAY REQUIRE ADDITIONAL INFORMATION FROM YOU OR YOUR PROVIDER BEFORE A CLAIM CAN BE CONSIDERED COMPLETE AND READY FOR PROCESSING. IN ORDER TO PROPERLY PROCESS A CLAIM, THE PLAN MAY BE REQUIRED TO ADD AN ADMINISTRATIVE POLICY LINE TO THE CLAIM. DUPLICATE CLAIMS PREVIOUSLY PROCESSED WILL BE DENIED.

This section describes how We determine the amount of reimbursement for Covered Services. Reimbursement for Dental Services rendered by Participating and Non-Participating Dentists is based on the Maximum Allowed Amount for the type of service performed. There may be different levels of reimbursement for the Maximum Allowed Amount depending upon whether you elect to receive services from a Participating or a Non-Participating Dentist.

The Maximum Allowed Amount is the maximum amount of reimbursement Anthem will pay for Dental Services provided by a Dentist to a Member and which meet Our definition of a Covered Service. For Participating Dentists, the Maximum Allowed Amount will be reimbursed according to the Schedule of Maximum Allowable Charges. For Non-Participating Dentists, the Maximum Allowed Amount will be reimbursed according to the Table of Allowances.

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

When you receive Covered Services from a Dentist, We will apply 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 Our determination of the Maximum Allowed Amount. 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, Our payment will be based on a single Maximum Allowed Amount for the single procedure code rather than a separate Maximum Allowed Amount for each billed procedure amount.

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 Amount 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 be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Dentist or a Non-Participating Dentist. There may be different levels of reimbursement for the Maximum Allowed Amount depending upon whether you elect to receive services from a Participating Dentist or a Non-Participating Dentist.

Participating Dentists

A Participating Dentist is a Dentist who has signed a written provider service agreement agreeing to service the program identified in this Certificate. For Covered Services performed by a Participating Dentist, the Maximum Allowed Amount is based upon the lesser of the Dentist's actual charges or the Schedule of Maximum Allowable Charges. Because Participating Dentists have agreed to accept the Maximum Allowed Amount as payment in full for services, they should not send you a bill or collect for amounts above the agreed upon Maximum Allowed Amount. However, you may receive a bill or be asked to pay a portion of the Maximum Allowed Amount to the extent you have exhausted your coverage for the service, have not met your Deductible, have a Coinsurance, have received non-covered services, or have exceeded the dental benefit maximum as outlined in the Summary of Benefits. Please call Our Customer Service Department at (877) 604-2156 for help in finding a Participating Dentist or visit Our website at www.anthem.com/mydentalvision.

Non-Participating Dentists

Dentists who have NOT signed a written provider service agreement agreeing to service the program identified in this Certificate are considered Non-Participating Dentists. For Covered Services you receive from a Non-Participating Dentist, the Maximum Allowed Amount will be the lesser of the Dentist's actual charges or an amount based on Our Non-Participating Dentist fee schedule, referred to as the Table of Allowances, which We have established in Our discretion, and which We reserve the right to modify from time to time after considering one or more of the following: reimbursement amounts accepted by similar providers contracted with Us, and other industry cost, reimbursement and utilization data. The Table of Allowances may be different from the Maximum Allowed Amount reimbursed to Participating Dentists.

Unlike Participating Dentists, Non-Participating Dentists may send you a bill and collect for the amount of the Dentist's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Non-Participating Dentist charges. This amount may be significant. Choosing a Participating Dentist will likely result in lower out of pocket costs to you. Please call Customer Service Department at (877) 604-2156 for help in finding a Participating Dentist or visit Our website at www.anthem.com/mydentalvision.

Customer Service is also available to assist you in determining the Maximum Allowed Amount for a particular service from a Non-Participating Dentist. In order for Us to assist you, you will need to obtain the specific procedure code(s) from your Dentist 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 Maximum Allowed Amount for your claim will be based on the actual claim submitted.

MEMBER COST SHARE

For certain Covered Services and depending on your dental program, you may be required to pay a part of the Maximum Allowed Amount (for example, Deductible and/or Coinsurance). Your Deductible and Coinsurance cost share amount and out-of-pocket limits may vary depending on whether you received services from a Participating or Non-Participating Dentist. Specifically, you may pay higher cost sharing amounts or incur benefit limits when using Non-Participating Dentists. Please see the Summary of Benefits in this Certificate for your cost share responsibilities and limitations, or call Customer Service to learn how this Certificate's benefits or cost share amounts may vary by the type of Dentist you use.

Payment of Benefits

You authorize Us to make payments directly to Participating Dentists for Covered Services. We also reserve the right to make payments directly to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by Us will discharge Our obligation to pay for Covered Services.

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

The Member is responsible for all treatment charges made by a Non-Participating Dentist. When services are obtained from a Non-Participating Dentist, any benefits payable under the group contract are paid directly to the Member unless you assign the payment directly to the provider of the dental service by indicating so on the claim form.

Notice of Claim

We are not liable under the Certificate, unless We receive written notice that Covered Services have been given to you. An expense is considered incurred on the date the service or supply was given.

The notice must be given to Us within 12 months of receiving the Covered Services, and must have the data We need to determine benefits. Failure to give Us notice within 12 months will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice can be submitted later than one year after the usual 12 month filing period ends. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the time frames specified in this provision or no benefits will be payable except as otherwise required by law.

Any benefits due under this Certificate shall be due once We have received proper, written proof of loss, together with such reasonably necessary additional information We may require to determine Our obligation. In the event We do not pay a claim within 30 days of receipt of proof of loss, We will pay interest at the rate required by law on the benefits due under the terms of the Certificate.

Claims should be submitted to:

Anthem Blue Cross and Blue Shield
PO Box 1115
Minneapolis, MN 55440-1115
(877) 604-2156

Proof of Claim

Written proof of claim satisfactory to Us must be submitted to Us within 12 months after the date of the event for which claim is made. If proof of claim is not sent within the time required, the claim will not be reduced or denied if it was not possible to send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to Us no later than one year following the 12 month period specified, unless you were legally incapacitated.

Claim Forms

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

- Name of patient
- Patient's relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the 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 will be responsible for any charge for services.

Explanation of Benefits

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

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

COVERED SERVICES

Pretreatment Estimate (Estimate of Benefits)

IT IS RECOMMENDED, BUT NOT REQUIRED, THAT A PRETREATMENT ESTIMATE BE SUBMITTED TO ANTHEM PRIOR TO TREATMENT IF YOUR DENTAL TREATMENT INVOLVES MAJOR RESTORATIVE, PERIODONTICS, PROSTHETICS OR ORTHODONTIC CARE (SEE DESCRIPTION OF COVERAGES), TO ESTIMATE THE MAXIMUM ALLOWED AMOUNT. THE PRETREATMENT ESTIMATE IS A VALUABLE TOOL FOR BOTH THE DENTIST AND YOU. SUBMITTING A PRETREATMENT ESTIMATE ALLOWS THE DENTIST AND YOU TO KNOW WHAT BENEFITS ARE AVAILABLE TO YOU BEFORE BEGINNING TREATMENT. THE PRETREATMENT ESTIMATE WILL OUTLINE YOUR RESPONSIBILITY TO THE DENTIST WITH REGARD TO COINSURANCE, DEDUCTIBLES AND NON-COVERED SERVICES. THIS WILL ALLOW THE DENTIST AND YOU TO MAKE ANY NECESSARY FINANCIAL ARRANGEMENTS BEFORE TREATMENT BEGINS. THIS PROCESS DOES NOT PRIOR AUTHORIZE THE TREATMENT NOR DETERMINE ITS DENTAL OR MEDICAL NECESSITY. THE ESTIMATED MAXIMUM ALLOWED AMOUNT IS BASED ON YOUR CURRENT ELIGIBILITY AND CONTRACT BENEFITS IN EFFECT AT THE TIME OF THE COMPLETED SERVICE. SUBMISSION OF OTHER CLAIMS OR CHANGES IN ELIGIBILITY OR THE CONTRACT MAY ALTER FINAL PAYMENT. THIS IS NOT A GUARANTEE OF BENEFITS.

After the examination, your Dentist will establish the dental treatment to be performed. If the dental treatment necessary involves major restorative, periodontics, prosthetics or orthodontic care, you should submit a claim form to Anthem outlining the proposed treatment. Anthem will determine if the proposed treatment is covered and estimate the Maximum Allowed Amount, including your responsibility for Coinsurance, Deductibles and non-covered services.

A statement will be sent to you and your Dentist estimating the amount of the Maximum Allowed Amount, including the amount that you will owe. These estimates will be subject to your continuing eligibility and the Group Contract remaining in effect. If claims for other completed Dental Services are received and processed prior to the completion date of the proposed treatment, this may reduce Anthem's estimated Maximum Allowed Amount for the proposed treatment and increase your obligation to the Dentist.

TO AVOID ANY MISUNDERSTANDING OF THE MAXIMUM ALLOWED AMOUNT OR THE AMOUNT THAT YOU WILL OWE, ASK YOUR DENTIST ABOUT HIS OR HER PARTICIPATION STATUS AND IF HE OR SHE HAS AGREED TO SERVICE THIS DENTAL PROGRAM PRIOR TO RECEIVING DENTAL CARE.

You will be responsible for payment of any Deductibles and Coinsurance amounts and any dental treatment that is not considered a Covered Service under your Certificate.

The Plan covers the following Dental Procedures when they are performed by a licensed Dentist and when necessary and customary as determined by the standards of generally accepted dental practice. The benefits under this Certificate shall be provided whether the Dental Procedures are performed by a duly licensed physician or a duly licensed Dentist, if otherwise covered under this Certificate, provided that such Dental Procedures can be lawfully performed within the scope of a duly licensed Dentist.

As a condition precedent to the approval of claim payments, the Plan shall be entitled to request and receive, to such extent as may be lawful, from any attending or examining Dentist, or from hospitals in which a Dentist's care is provided, such information and records relating to a Member as may be required to pay claims. Also, the Plan may require that a Member be examined by a dental consultant retained by Anthem in or near the Member's place of residence. Anthem and the Plan shall hold such information and records confidential.

Anthem does not determine whether a service submitted for payment or benefit under this Certificate is a Dental Procedure that is dentally necessary to treat a specific condition or restore dentition for an individual. The Plan evaluates Dental Procedures submitted to determine if the procedure is a covered benefit. Your coverage includes a preset schedule of Dental Services that are eligible for benefit by Anthem. Other Dental Services may be recommended or prescribed by your Dentist which are dentally necessary, offer you an enhanced cosmetic appearance, or are more frequent than covered by Anthem. While these services may be prescribed by your Dentist and are dentally necessary for you, they may not be a Dental Service that is covered by Anthem or they may be a service where Anthem provides a payment allowance for a service that is considered to be optional treatment. If Anthem gives you a payment allowance for optional treatment that is covered, you may apply this Anthem payment to the service prescribed by your Dentist which you elected to receive. Services that are not covered by Anthem or exceed the frequency of plan benefits do not imply that the service is or is not dentally necessary to treat your specific dental condition. You are responsible for Dental Services that are not covered or covered by Anthem. Determination of services necessary to meet your individual dental needs is between you and your Dentist.

ONLY those services listed below are covered. Deductibles and Dental Benefit Maximums are listed under the Summary of Benefits. Covered Services are subject to the limitations within the Benefits, Exclusions and Limitations sections described below. For estimates of Covered Services, please see the "Pretreatment Estimate" section of this Certificate.

Preventive Care (Diagnostic & Preventive Services)

Oral Evaluations - Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

NOTE: Comprehensive oral evaluations will be covered 1 time per dental office, subject to the 2 times per calendar year limitation. Any additional comprehensive oral evaluations performed by the same dental office will be covered as a periodic oral evaluation and will be subject to the 2 times per calendar year limitation.

Radiographs (X-rays)

- **Bitewings** - Covered at 1 series of bitewings per 12-month period.
- **Full Mouth (Complete Series) or Panoramic** - Covered 1 time per 60-month period.
- **Periapical(s)** - 4 single x-rays are covered per 12-month period.
- **Occlusal** - Covered at 2 series per 24-month period.

Dental Cleaning

- **Prophylaxis** - Any combination of this procedure and Periodontal Maintenance (see Periodontal Services section) is covered 2 times per calendar year.

Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

NOTE: A prophylaxis performed on a Member under the age of 14 will be covered as a child prophylaxis. A prophylaxis performed on a Member age 14 or older will be covered as an adult prophylaxis.

Fluoride Treatment (Topical application of fluoride) - Covered 1 time per 12-month period for Dependent children through the age of 18.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered 1 time per 24 month period for permanent first and second molars of eligible Dependent children through the age of 15.

EXCLUSIONS - Coverage is NOT provided for:

1. Oral hygiene instructions.
2. Amalgam or composite restorations placed for preventive or cosmetic purposes.

Basic Restorative Services

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth.

Composite (white) Resin Restorations

- **Anterior (front) Teeth** - Treatment to restore decayed or fractured permanent or primary anterior (front) teeth.
- **Posterior (back) Teeth** - Treatment to restore decayed or fractured permanent or primary posterior (back) teeth.

Benefits shall be limited to the same surfaces and allowances for amalgam (silver filling). The patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and the optional treatment, plus any Deductible and/or Coinsurance for the covered benefit.

LIMITATION: Coverage for amalgam or composite restorations shall be limited to only 1 service per tooth surface per 24-month period.

Basic Extractions

- Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Space Maintainers - Covered 1 time per lifetime on eligible Dependent children through the age of 16 for extracted primary posterior (back) teeth.

LIMITATION: Repair or replacement of lost/broken appliances are not a covered benefit.

EXCLUSIONS - Coverage is NOT provided for:

1. Case presentation and office visits.
2. Athletic mouthguard, enamel microabrasion, and odontoplasty.
3. Services or supplies that have the primary purpose of improving the appearance of the teeth. This includes but is not limited to whitening agents, tooth bonding and veneers.
4. Placement or removal of sedative filling, base or liner used under a restoration.
5. Pulp vitality tests.
6. Diagnostic casts.
7. Adjunctive diagnostic tests.

8. Restorations placed for preventive or cosmetic purposes.
9. Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.
10. Analgesia, analgesia agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care.
11. Brush biopsy.

Endodontic Services (Nerve or Pulp Treatment)

Endodontic Therapy on Primary Teeth

- **Pulpal Therapy**
- **Therapeutic Pulpotomy**

Endodontic Therapy on Permanent Teeth

- **Root Canal Therapy**
- **Root Canal Retreatment**

LIMITATION: All of the above procedures are covered 1 time per tooth per lifetime.

EXCLUSIONS - Coverage is NOT provided for:

1. Retreatment of endodontic services that have been previously covered under the Certificate.
2. Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
3. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
4. Intentional reimplantation.
5. Apicoectomy.
6. Root Amputation.
7. Apexification.
8. Retrograde filling.
9. Hemisection.
10. Pulp vitality tests.
11. Incomplete root canals.

Periodontal Services (Gum & Bone Treatment)

Periodontal Maintenance - A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed previous surgical or nonsurgical periodontal treatment.

LIMITATION: Any combination of this procedure and dental cleanings (see Diagnostic and Preventive section) is covered 2 times per calendar year.

Basic Non Surgical Periodontal Care - Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- **Periodontal scaling & root planing** - Covered 1 time per 36 months if the tooth has a pocket depth of 4 millimeters or greater.
- **Full mouth debridement** - Covered 1 time per lifetime.

Complex Surgical Periodontal Care - Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services under this Certificate:

- **Gingivectomy/gingivoplasty;**
- **Gingival flap;**
- **Apically positioned flap;**
- **Osseous surgery;**
- **Bone replacement graft;**
- **Pedicle soft tissue graft;**
- **Free soft tissue graft;**
- **Subepithelial connective tissue graft;**
- **Soft tissue allograft;**
- **Combined connective tissue and double pedicle graft;**
- **Distal/proximal wedge - LIMITATION: Covered on natural teeth only**

LIMITATION: Only 1 complex surgical periodontal service is a benefit covered 36-month period per single tooth or multiple teeth in the same quadrant and only if the pocket depth of the tooth is 5 millimeters or greater.

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as crown lengthening.
2. Bacteriologic tests for determination of periodontal disease or pathologic agents.
3. The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
4. Provisional splinting, temporary procedures or interim stabilization of teeth.
5. Analgesia, analgesic agents, anxiolysis, inhalation of nitrous oxide or therapeutic drug injections, drugs, or medicaments for non-surgical and surgical periodontal care, regardless of the method of administration.

Oral Surgery Services (Tooth, Tissue, or Bone Removal)

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth

- Surgical removal of residual tooth roots

LIMITATION: Surgical removal of 3rd molars are only covered if the removal is associated with symptoms or oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

LIMITATION: The Other Complex Surgical Procedures are covered only when required to prepare for dentures and is a benefit covered once in a 60 month period.

Adjunctive General Services

- **Intravenous Conscious Sedation, IV Sedation and general anesthesia** - Covered when performed in conjunction with complex surgical service.

LIMITATION: Intravenous conscious sedation, IV sedation and general anesthesia will not be covered when performed with non-surgical dental care.

Surgical reduction of fibrous tuberosity - Covered 1 time per 6-month period.

Temporomandibular Joint Disorder (TMJ)

Dental treatment that is considered surgical and nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder, including splints, is subject to the coordination of benefits. A Pre-treatment Estimate of Benefits is recommended. NOTE: If you or your Dependents currently have medical insurance coverage, the claim must be first submitted to that medical insurance program. Any remaining costs after consideration under your medical insurance may be submitted to the Plan for further benefit (see Coordination of Benefits). You must submit a copy of the medical Explanation of Benefits (EOB) along with your claim to the Plan.

If you or your Dependents are not eligible for TMJ benefits under another insurance program, either medical or dental, Dental Services for TMJ will be covered under this Certificate within the noted Certificate limitations, maximums, Deductibles and payment percentages of treatment costs.

LIMITATIONS

1. Reconstructive Surgery benefits shall be provided for reconstructive surgery when such Dental Procedures are incidental to or follows surgery resulting from injury, illness or other diseases of the involved part, or when such Dental Procedure is performed on a covered Dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, however that such procedures are dental reconstructive surgical procedures.
2. Inpatient or outpatient dental expenses arising from dental treatment up to age 18, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate.

For programs without orthodontic coverage: Dental orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this Certificate.

For programs with orthodontic coverage: If coverage for the treatment of cleft lip or cleft palate is available under any other policy or contract of insurance, this Certificate shall be primary and the other policy or contract shall be secondary.

EXCLUSIONS - Coverage is NOT provided for:

1. Intravenous conscious sedation, IV sedation and general anesthesia when performed with non-surgical dental care.
2. Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration.
3. Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
4. Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants.
5. Any oral surgery except for simple and surgical extractions.
6. Surgical repositioning of teeth.
7. Inpatient or outpatient hospital expenses.
8. Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.

Major Restorative Services (Crowns, Inlays and Onlays)

Services performed to restore lost tooth structure as a result of decay or fracture

Gold foil restorations - Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances.

LIMITATION: The patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Services and optional treatment, plus any Deductible and/or Coinsurance for the covered benefit. Covered 1 time per 24-month period.

Inlays - Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

LIMITATION: If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and optional treatment, plus any Deductible and/or Coinsurance for the Covered Service.

Pre-fabricated or Stainless Steel Crown - Covered 1 time per 60-month period for eligible Dependent children through the age of 18.

Onlays and/or Permanent Crowns - Covered 1 time per 7 year period per tooth for Members age 12 and older if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth.

LIMITATION: Porcelain/ceramic substrate onlays/crowns - Benefits will be limited to the Maximum Allowed Amount for a porcelain to noble metal crown. The patient must pay the difference in cost between the allowed fee for the Covered Service and optional treatment, plus any Deductible and/or Coinsurance for the covered benefit.

Implant Crowns - See Prosthodontic Services.

Recement Inlay, Onlay and Crowns - Covered 6 months after initial placement.

Crown Repair - Covered 1 time per 12-month period per tooth when the submitted narrative from the treating Dentist supports the procedure.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface - Covered 1 time per 7 year period when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
2. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
3. Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
4. Placement or removal of sedative filling, base or liner used under a restoration.
5. Canal prep & fitting of preformed dowel & post.
6. Temporary, provisional or interim crown.
7. Occlusal procedures.
8. Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.

Prosthodontic Services (Dentures, Partials, and Bridges)

Tissue Conditioning - Covered 1 time per 24-month period.

Recement Fixed Prosthetic - Covered 1 time per 12 months.

Reline and Rebase - Covered 1 per 24-month period:

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) - Covered 1 per 6-month period:

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge); and
- when the submitted narrative from the treating Dentist supports the procedure.

Denture Adjustments - Covered 2 times per 12-month period:

- when the denture is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the denture.

Partial and Bridge Adjustments - Covered 2 times per 24-month period:

- when the partial or bridge is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) - Covered 1 time per 7 year period:

- for Members age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if 7 years have elapsed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial needs replacement because it cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) - Covered 1 time per 7 year period:

- for Members age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if no more than 3 teeth are missing in the same arch;
- a natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- no other missing teeth in the same arch that have not been replaced with a removable partial denture;
- if none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 7 years;
- if 7 years have elapsed since the last covered removable prosthetic appliance (bridge) and the existing bridge needs replacement because it cannot be repaired or adjusted.

LIMITATION: If there are multiple missing teeth, a removable partial denture may be the benefit since it would be the least costly, commonly performed course of treatment. Please refer to the Optional Treatment Plans section. The optional benefit is subject to all contract limitations on the Covered Service.

Implant Supported Fixed and Removable Prosthetic (Crowns, Bridges, Partials and Dentures) - A restoration that is retained, supported and stabilized by an implant. Implants and related services are NOT covered.

LIMITATION: This procedure receives an optional treatment benefit equal to the least expensive professionally acceptable treatment. The additional fee is the patient's responsibility. For example: A single crown to restore one open space will be given the benefit of a Fixed Partial Denture Pontic (one unit). The optional benefit is subject to all contract limitations on the Covered Service.

EXCLUSIONS - Coverage is NOT provided for:

1. The replacement of an existing partial denture with a bridge.
2. Initial installation of an implant(s), full or partial dentures or fixed bridgework to replace a tooth (teeth) which was extracted prior to becoming a Member under this Certificate. **EXCEPTION:** This exclusion shall not apply for any person who has been continuously covered under this Certificate for more than 24 months.
3. Coverage for congenitally missing teeth. **EXCEPTION:** This exclusion shall not apply for any person who has been continuously covered under this Certificate for more than 24 months.
4. Interim removable or fixed prosthetic appliances (dentures, partials or bridges).
5. Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
6. Additional, elective or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments.

7. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
8. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
9. Services or supplies that have the primary purpose of improving the appearance of your teeth.
10. Placement or removal of sedative filling, base or liner used under a restoration.
11. Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants.
12. Implant maintenance or repair to an implant or implant abutment.

Coverage shall be limited to the least expensive professionally acceptable treatment.

Enhanced benefit for Members who are pregnant or who have diabetes

Enhanced dental benefits are available for Members who are pregnant or diagnosed with Type 1 or Type 2 diabetes. Members diagnosed with gestational diabetes are eligible for benefits due to pregnancy or diabetes, but not both.

A member who is pregnant or diagnosed with gestational diabetes is eligible for one additional benefit for a maximum of two Coverage Years. A member diagnosed with Type 1 or Type 2 diabetes is eligible for one additional benefit per Coverage Year until their coverage with the Plan terminates. The enhanced benefits include a maximum of one of the following procedures:

- Prophylaxis-adult
- Periodontal maintenance. Covered only when following active periodontal therapy.

To obtain the additional benefit(s), the Member must complete the enhanced benefit application enrollment form and submit it to Us at:

Anthem Dental Claims
Attention: Clinical Integration Coordinator
P.O. Box 1115
Minneapolis, MN 55440-1115.

It is important to note that the enhanced benefit(s) will not count toward the Coverage Year Maximum benefit.

EXCLUSIONS

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

Coverage is NOT provided for:

- a) Dental Services which a Member would be entitled to receive for a nominal charge or without charge if this Certificate were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Member receives a bill or direct charge for Dental Services under any governmental program, then this exclusion shall not apply. Benefits under this Certificate will not be reduced or denied because Dental Services are rendered to a Subscriber or Dependent who is eligible for or receiving Medical Assistance.
- b) Dental Services or health care services not specifically covered under the Group Contract (including any hospital charges, prescription drug charges and Dental Services or supplies that are medical in nature).
- c) New or unproven dental techniques or services may be denied until there is an established scientific basis for recommendation.
- d) Dental Services performed for cosmetic purposes.
- e) Dental Services completed prior to the date the Member became eligible for coverage.
- f) Services of anesthesiologists.
- g) Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a Dentist or an employee of the Dentist who is certified in their profession to provide anesthesia services.
- h) Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.
- i) Dental Services performed other than by a licensed Dentist, licensed physician, his or her employees.
- j) Dental Services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- k) Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants.
- l) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- m) Orthodontic treatment services, unless specified in this Certificate as a covered Dental Service benefit.
- n) Case presentations, office visits and consultations.
- o) Incomplete, interim or temporary services.
- p) Initial installation of an implant(s), full or partial dentures or fixed bridgework to replace a tooth (teeth) which was extracted prior to becoming a Member under this Certificate. EXCEPTION: This exclusion shall not apply for any person who has been continuously covered under this Certificate for more than 24 months.

- q) Corrections of congenital conditions during the first 24 months of continuous coverage under this Certificate.
- r) Athletic mouth guards, enamel microabrasion and odontoplasty.
- s) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Certificate.
- t) Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
- u) Bacteriologic tests.
- v) Cytology sample collection.
- w) Separate services billed when they are an inherent component of a Dental Service.
- x) Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
- y) Interim or temporary removable or fixed prosthetic appliances (dentures, partials or bridges).
- z) Services for the replacement of an existing partial denture with a bridge.
- aa) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- bb) Provisional splinting, temporary procedures or interim stabilization.
- cc) Placement or removal of sedative filling, base or liner used under a restoration.
- dd) Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
- ee) Oral hygiene instruction.
- ff) Occlusal procedures.
- gg) Any charges which exceed the Maximum Allowed Amount.
- hh) Implant maintenance or repair to an implant or implant abutment.
- ii) Pulp vitality tests.
- jj) Adjunctive diagnostic tests.
- kk) Diagnostic casts.
- ll) Incomplete root canals.
- mm) Cone beam images.
- nn) Anatomical crown exposure.
- oo) Temporary anchorage devices.
- pp) Sinus augmentation.
- qq) Restorations placed for preventive or cosmetic purposes.
- rr) Inlays, onlays and crowns placed for preventive or cosmetic purposes.

- ss) Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.
- tt) Recement Space Maintainers.
- uu) Consultations.
- vv) Orthodontic Services.
- ww) Brush biopsy.

Limitations

- a) **Optional Treatment Plans:** in all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Member and the Dentist; however, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Member.
- b) **Reconstructive Surgery:** benefits shall be provided for reconstructive surgery when such Dental Procedure is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part, or when such Dental Procedure is performed on a covered Dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, however that such services are dental reconstructive surgical services.
- c) **Benefits for inpatient or outpatient expenses arising from Dental Services up to age 18, including orthodontic and oral surgery services, involved in the management of birth defects known as cleft lip and cleft palate.** For programs without orthodontic coverage: Dental orthodontic services not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this dental benefit program. For programs with orthodontic coverage: If coverage for the treatment of cleft lip or cleft palate is available under any other policy or contract of insurance, this Certificate shall be primary and the other policy or contract shall be secondary.
- d) **Some procedures are an integral part of another completed service covered by the Certificate.** If the Dentist bills these procedures separately from the covered service, the Plan will disallow coverage for the separately billed procedures. You will then be responsible for any charge for the separately billed procedures and must pay your Dentist directly.

Optional Treatment Plans

In all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Member and the Dentist; however, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Member.

GENERAL PROVISIONS

Form or Content of Certificate

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

Relationship of Parties (Plan - Participating Dentists)

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

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

Your Participating 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 Participating Dentists and Non-Participating Dentists. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

Not Liable for Provider Acts or Omissions

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

Identification Card

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

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of the Plan, disability of a significant part of a Participating Dentist's personnel or similar causes, or the rendering of dental care services provided under this Certificate is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Participating Dentists shall render dental care services provided under this Certificate 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.

Employer Premiums

Your employer is responsible for paying a monthly Premium by the first day of the month for which coverage is purchased. We will allow employers a 31 day grace period to pay monthly Premiums, except for the first month's Premium. During this grace period, coverage will continue unless We receive a written notice of termination from your employer. We will notify your employer at least 15 days prior to terminating the Group Contract for non-payment of a monthly Premium. Anthem is not responsible for costs you incur during any period (other than the grace period discussed above) when your employer fails to pay full Premiums.

Coordination of Benefits (COB)

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), We 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. We may get the facts We need 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. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give Us 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, We 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. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Us is more than We should have paid under this COB provision, We may recover the excess from one or more of the persons We paid or for whom We 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 We have not paid a claim properly, you should first attempt to resolve the problem by contacting Us. Follow the steps described in the "Complaint and Appeals Procedures" section of the Certificate. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at <http://insurance.ohio.gov>.

Relationship of Parties (Group-Member-Plan)

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

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

Conformity with Law

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

Modifications

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

Physical Examination and Autopsy

We shall have the right to: (1) examine any Member for whom a claim is made when and as often as may be reasonably required during the pendency of a claim; and (2) perform an autopsy on any Member where it is not otherwise prohibited by law.

Legal Action

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

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

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

Reservation of Discretionary Authority

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

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

The Plan, or anyone acting on Our behalf, shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation and administration of the Certificate. This includes, without limitation, the power to construe the Group Dental Contract, to determine all questions arising under the Certificate, to resolve Member Grievances and Appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation and administration of the provisions of this Certificate. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Group Dental Contract, the Certificate, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

CLAIM AND APPEAL PROCEDURES

All claims should be submitted within 12 months of the date of service. An initial benefit determination on your claim will be made within 30 days after receipt of your claim. You will receive written notification of this benefit determination. The 30-day period may be extended for an additional 15 days if the claim determination is delayed for reasons beyond Our control. In that case, We will notify you prior to the expiration of the initial 30-day period of the circumstances requiring an extension and the date by which We expect to render a decision. If the extension is necessary to obtain additional information from you, the notice will describe the specific information We need, and you will have 45 days from the receipt of the notice to provide the information. Without complete information, your claim will be denied.

Appeals

In the event that We deny a claim in whole or in part, you have a right to a full and fair review. Your request to review a claim must be in writing and submitted within 180 days from the claim denial. We will make a benefit determination within 60 days following receipt of your appeal.

Your appeal must include your name, your identification number, group number, claim number, and dentist's name as shown on the Explanation of Benefits. Send your appeal to:

Anthem Blue Cross and Blue Shield
Attention: Appeals Unit
PO Box 1122
Minneapolis, MN 55440-1122

You may submit written comments, documents, or other information in support of your appeal. You will also be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the denied or reduced claim (whether or not presented or available at the initial determination) and the initial determination will not be given any weight.

The review will be conducted by someone different from the original decision-makers and without deference to any prior decision. Because all benefit determinations are based on a preset schedule of Dental Services eligible under your plan, claims are not reviewed to determine dental necessity or appropriateness. In all cases where professional judgment is required to determine if a procedure is covered under your plan's schedule of benefits, We will consult with a dental professional who has appropriate training and experience. In such a case, this professional will not be the same individual whose advice was obtained in connection with the initial adverse benefit determination (nor a subordinate of any such individual). In addition, We will identify any dental professional whose advice was obtained on Our behalf, without regard to whether the advice was relied upon in making the benefit determination. If, after review, We continue to deny the claim, you will be notified in writing.

Authorized Representative

You may authorize another person to represent you and with whom you want Us to communicate regarding specific claims or an appeal. However, no authorization is required for your treating dentist to make a claim or appeal on your behalf. The authorization form must be in writing, signed by you, and include all the information required in Our Authorized Representative form. This form is available at Our web site or by calling Customer Service Department at (877) 604-2156. You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

ANTHEM DENTAL

FOR CLAIMS AND ELIGIBILITY

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FOR APPEALS

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Approved 06/2020 (PDF only)