Administered by Anthem Health Plans of Kentucky, Inc.

Your Dental Benefit Booklet

Dental Benefit Booklet

Anthem Dental

Administered by:
ANTHEM HEALTH PLANS OF KENTUCKY, INC.
ANTHEM BLUE CROSS AND BLUE SHIELD
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Important: This is not an insured benefit plan. The benefits described in this Benefit Booklet or any rider or amendments hereto are funded by the Employer who is responsible for their payment. Anthem Health Plans of Kentucky, Inc.dba Anthem Blue Cross and Blue Shield provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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1 BENEFIT BOOKLET

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

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

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

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

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

Contents

2 MEMBER RIGHTS AND RESPONSIBILITIES

As a Member, You Have the Right to:

- Receive information regarding rules and regulations of your dental benefits;
- Be treated respectfully and with consideration;
- Receive all the benefits to which you are entitled under this Benefit Booklet;
- Obtain from a Provider complete information regarding your diagnosis, treatment and prognosis in terms you can reasonably understand;
- Receive quality dental care through Providers in a timely manner;
- Have a candid discussion of treatment options for your condition, regardless of cost or benefit coverage;
- Participate with your Physician in decision making about your dental care treatment;
- Refuse treatment and be informed by your Physician of the medical consequences;
- Express concerns and complaints about the care and services provided by Physicians and other Providers to the Administrator or the Employer and to have the Administrator, on behalf of the Employer, investigate and take appropriate action;
- File a complaint with the Administrator or the Employer, and to appeal that decision as outlined in the Complaint and Appeals Procedures section of this Benefit Booklet; and
- Confidentiality and privacy.

As a Member, You Have the Responsibility to:

- Use Providers who will provide or coordinate your total dental care needs, and to maintain an ongoing patient-Physician relationship;
- Provide complete and honest information about your dental care status;
- Follow the treatment plan recommended by your Providers;
- Notify the Provider or the Administrator or your Employer about concerns you have regarding the services or dental care you receive;
- Be considerate of the rights of other Members, Providers and the Administrator's staff;
- Read and understand this Benefit Booklet; and
- Provide accurate and complete information to the Administrator or the Employer about other health/dental care coverage and/or benefits you may carry.

3 SCHEDULE OF BENEFITS

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

Benefits for Covered Services are based on the Maximum Allowable Amount. When you utilize a Non-Network Provider you are responsible for any balance due between the Non-Network Provider's charge and the Maximum Allowable Amount in addition to any Copayments, Deductibles, and non-covered charges.

BENEFIT PERIOD	Calendar Year
DEPENDENT AGE LIMIT	To the end of the calendar year in which the child attains age 26.
ORTHODONTIC AGE LIMIT	Benefits are provided for the Subscriber and/or the Subscriber's spouse. To the date the child attains age 19.

DEDUCTIBLE	**Network and Non-Network combined**
Per Member	$50
Per Family	$150

Note: Any amounts applied to the Deductible for expenses incurred during the last three months of the Benefit Period will be applied to the next Benefit Period's Deductible.

	Network	**Non-Network**
ANNUAL MAXIMUM (Network and Non-Network combined)	$1,000	$1,000
ORTHODONTIC LIFETIME MAXIMUM - Network and Non-Network combined (does not apply to the Annual Maximum)	$1,000	$1,000

COVERED SERVICES	COPAYMENTS/MAXIMUMS	
	Network	**Non-Network**
Diagnostic and Preventive Services (Not subject to the Deductible)	Covered In Full, up to the Maximum Allowable Amount	Covered In Full, up to the Maximum Allowable Amount

The following services are subject to the Deductible

	Network	**Non-Network**
General (Adjunctive) Services	20%	20%
Restorative Services	20%	20%
Endodontic Services	20%	20%
Oral Surgery Services	20%	20%
Periodontal Services	20%	20%
Prosthodontic Services	50%	50%
Orthodontic Services (Not subject to the Deductible)	50%	50%

4 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.

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

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

Administrator - An organization or entity that the Employer contracts with to provide administrative and claims payment services under the Plan. The Administrator is Anthem Health Plans of Kentucky, Inc. The Administrator provides administrative claims payment services

only and does not assume any financial risk or obligation with respect to claims.

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

Annual Maximum - The maximum dollar amount payable for Covered Services for each Member during a Benefit Period. The Benefit Period is listed in the Schedule of Benefits. The amounts applied to the Annual Maximum are based on the Maximum Allowable Amount for all Covered Services. The annual benefit limit includes both Network and Non-Network services, but does not include the Member's Deductible or Copayment amounts. If your benefit plan covers Orthodontics, benefits for orthodontic services are not included in the Annual Maximum, but are subject to a separate Lifetime Maximum orthodontic benefit amount. Refer to the Schedule of Benefits for any Annual Maximums or Lifetime Maximum amounts.

Appliance - A device used to provide a function or a therapeutic effect (example: a denture).

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

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

Cleft Palate - A birth deformity in which the palate (the roof of the mouth) fails to close.

Cleft Lip - A birth deformity in which the lip fails to close.

Copayment - A specific dollar amount or percentage of the Maximum Allowable Amount for Charges for Covered Services indicated in the Schedule of Benefits for which you are responsible. The Copayment does not apply towards any Deductible.

Covered Services - Services, supplies or treatment as described in this Benefit Booklet which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

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

Deductible - The dollar amount of Covered Services listed in the Schedule of Benefits for which you are responsible before benefits are payable under the Plan for Covered Services each Benefit Period.

Dependent - A Subscriber's spouse and dependent children who are eligible for benefits under the Plan as described in the Eligibility and Enrollment section.

Effective Date - The date your coverage begins under the Plan. You must be Actively At Work on your Effective Date. If you are not Actively At Work on your scheduled Effective Date, your Effective Date will be the date you become Actively At Work. A Dependent's coverage begins on the Effective Date of the sponsoring Subscriber.

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

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

Enrollment Date - The first day benefits are effective under the Plan or, if there is a waiting period, the first day of the waiting period (typically the date employment begins).

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

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

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

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

Late Enrollment - Enrollment other than on:

- The earliest date on which benefits can become effective under this Plan; or
- The date of an event that qualifies for Special Enrollment.

Maximum Allowable Amount (Maximum Allowed Amount) - The maximum amount that the Plan will allow for Covered Services You receive. For more information, see the "Claims Payment" section.

Medicare - The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

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

Network Provider - A Provider who has entered into a contractual agreement or is otherwise engaged by the Administrator or the Subcontractor, to provide Covered Services and certain administration functions for the Network associated with this Benefit Booklet.

Non-Network Provider - A dental care Provider who has not entered into a contractual agreement with the Administrator or the Subcontractor for the Network associated with this Benefit Booklet.

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

Pre-Existing Condition - A condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the time period specified in the Schedule of Benefits, ending on your Enrollment Date. Domestic violence is not considered a Pre-Existing Conditions. Genetic information may not be used as a condition in the absence of a diagnosis.

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

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

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

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

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

Single Coverage - Coverage for the Subscriber only.

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

duties on behalf of the Administrator and/or the Employer.

Subscriber - An eligible employee, retired employee, or member of the Employer enrolled under the Plan and whose name benefits are in effect.

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

5 ELIGIBILITY AND ENROLLMENT

Benefits payable under the Plan are available to you because of your employment with, or membership with the Employer.

In order for you to participate in this dental benefit plan, certain requirements must be satisfied. These requirements may include probationary or waiting periods, and Actively at Work standards. The specific time periods and other standards for participation in the Employer's benefit plan are determined by the Employer, or state and/or federal law. Eligibility requirements are described in general terms below.

For more specific eligibility information you should see your Human Resources or benefits department.

Eligibility

Unless the Employer notifies you otherwise, the following eligibility rules apply:

Note: If both employees that work for the Diocese are full time, have NO dependents, they should enroll in single plans.

Note: If both employees that work for the Diocese are full time, have dependents, they should enroll in the family plan.

Subscriber

To be eligible to enroll as a Subscriber, an individual must be an employee of the Employer who is entitled to participate in the benefit plan arranged by the Employer, who has satisfied any probationary or waiting period established by the Employer, who is Actively At Work, and who meets the Plan's eligibility criteria.

Dependents

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

- The Subscriber's legal spouse.
- The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children. The event date for an adopted child is the earlier of the date of adoption or date of placement for adoption. Placement for adoption means the assumption and retention of legal obligation for total and partial support for a child in anticipation of adoption of such child. (Included are natural children, adopted children and children who the Employer has determined are covered under a "Qualified Medical Child Support Order" as defined by any applicable state law).
- Children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law.

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

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves due to mental

retardation or physical 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 benefits. The Employer, must certify the Dependent's eligibility. The Employer must be informed of the Dependent's eligibility for continuation of coverage within 31 days after the Dependent would normally become ineligible. The Employer may require continued proof of such disability annually after the two year period following this child's attainment of the limiting age.

The Employer 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 benfits under the Plan.

To enroll children under the Plan, the Subscriber may be required to complete a "Dependency Affidavit" and provide the Employer with a copy of any legal documents awarding guardianship of such child(ren) to the Subscriber. Temporary custody is not sufficient to establish eligibility under the Plan.

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

College Student Medical Leave

The Plan will extend coverage for up to one year when a college student otherwise would lose eligibility, if a child takes a Medically Necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless Dependent coverage ends earlier under another Plan provision, such as the parent's termination of employment or the child's age exceeding the Plan's limit.

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

Enrollment

Persons who are eligible to enroll as Members must enroll at the time agreed upon by the Employer . Otherwise, they may only enroll during the Open Enrollment period or during a Special Enrollment period, whichever is applicable.

Initial Enrollment

An Eligible Person can enroll for Single or Family Coverage by submitting an application to the Employer. That application must be received by the date established by the Employer, and agreed to by the Administrator for initial application for enrollment. If the Administrator does not receive the initial application by this date, the Eligible Person can only enroll for benefits during the Open Enrollment period or during a Special Enrollment period, which ever is applicable.

If a Dependent of the Eligible Person qualifies as a Dependent with the Plan at the time of the Eligible Person's initial application for enrollment, but does not enroll in this dental plan, that person can only enroll for dental benefits during the open enrollment period or during a special enrollment period, which ever is applicable.

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

Newly Eligible Persons

Any person who becomes newly eligible after the initial Enrollment period (e.g., new spouse, adopted child, newly hired or newly transferred Subscriber), is eligible for coverage effective on the first date eligible only if all of the following conditions are met:

- The enrollment form must be received by the Administrator within thirty (31) days of becoming eligible; and
- Timely payment of the applicable enrollment fees.

A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; 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 or the child may not reapply for coverage until the Employer's next annual enrollment. Coverage will be effective on the date the court awards legal custody or guardianship if the Administrator receives application within 31 days of that qualifying event.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by applicable state law, to enroll your child under this Plan, the Employer will permit your child to enroll without regard to any enrollment limits and shall provide the benefits of the Plan in accordance with the applicable requirements of such order. A child's coverage under this provision will not extend beyond the Dependent Age Limit listed in the Schedule of Benefits. Any claims payable under the Plan will be paid at the Administrator's discretion, to the child, custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. The Administrator, on behalf of the Employer, will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to the Employer or Administrator directly.

Special Enrollment

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

If the Administrator or the Administrator's designee, on behalf of the Employer, receives an application to add your Dependent or an Eligible Person and Dependent more than 31 days after the qualifying event, that person is only eligible for coverage as a Late Enrollee. Application forms are available from the Administrator or the Employer.

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

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

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

Application forms are available from the Employer.

Open Enrollment

An Eligible Person or Dependent who did not request enrollment for dental coverage during the initial enrollment period or 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 during which the individual was first entitled to enroll may only apply for coverage during the Employer's next annual enrollment and may be subject to a Pre-Existing Condition waiting period.

Changes in Coverage and Eligibility

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.

If a Subscriber wants to add a newly eligible Dependent due to marriage, birth, adoption, award of legal custody or guardianship, or loss of group dental coverage, the Subscriber must apply for coverage for that person even if enrolled for Family Coverage. That family member must be enrolled within 31 days of the event: birth, adoption, or placement for adoption, marriage, or other qualifying event. If you apply to add this person within 31 days of the event which caused the family member to become eligible, the Dependent will be covered as of the date of the event. If the Administrator receives an application to add a Dependent more than 31 days after the qualifying event, that person is only eligible for coverage during the Open Enrollment period.

Application forms are available from the Administrator.

Notice of Eligibility Changes

The Subscriber is responsible to notify the Employer and/or the Administrator of any changes which will affect his or her eligibility or that of Dependents for services or benefits under the Plan. The Employer and/or the Administrator must be notified of any changes as soon as possible but no later than within 31 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status, enrollment or disenrollment in another dental plan or Medicare.

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

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

Effective Date of Coverage

For information on your specific Effective Date of Coverage, you should see your Human Resources or benefits department.

Continuous Coverage

If you were previously covered by a plan with the Employer and the Administrator immediately prior to enrolling in this Plan, with no break in coverage, you will receive credit for any accrued Deductibles (if applicable). However, any Annual Maximums used under that plan will be carried over and charged against the Annual Maximums under this Plan. If your benefit plan provides for

Orthodontic coverage, any Orthodontic Lifetime Maximums used under that plan will be carried over and charged against the Orthodontic Lifetime Maximum under this Plan.

Statements and Forms

Subscribers or applicants for benefits shall complete and submit to the Administrator applications, or other forms or statements the Administrator may reasonably request. Subscribers or applicants for benefits represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Administrator are true, correct, and complete. Subscribers and applicants for coverage understand that all rights to benefits under the Plan 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 Termination section.

Delivery of Documents

The Administrator, on behalf of the Employer, will provide an Identification Card for each Member and a Benefit Booklet for each Subscriber.

6 TERMINATION AND CONTINUATION

Termination

It is the responsibility of the Employer to notify you of the termination of this dental Plan.

Except as otherwise provided, your benefits will terminate as follows:

- If you cease to meet eligibility requirements as outlined in this Benefit Booklet, your benefits will terminate automatically at midnight of the last day of the period for which Fees have been paid. You shall notify the Administrator and/or the Employer immediately if you cease to meet the eligibility requirements. You shall be responsible for payment for any services Incurred by you after you cease to meet eligibility requirements.
- If you engage in fraudulent conduct or furnish the Employer or the Administrator with fraudulent or misleading material information relating to claims or application for benefits, then the Employer may terminate your benefits. Termination is effective 31 days after the notice of termination is mailed. You shall be responsible to pay the Employer for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or fees paid for such services. The Employer will also terminate your Dependent's benefits, effective on the date your benefits were terminated.
- If you stop being a Subscriber or do not pay the required contribution, benefits terminate for all Members at the end of the period for which payment was made.
- If a Dependent, benefits terminate on the date that person no longer meets the definition of Dependent.
- If coverage is through an association, benefits terminate on the date Membership in the association ends.

Conversion

Conversion coverage is not available under this Plan.

Family and Medical Leave Act

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

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

Continuation of Coverage Due To Military Service

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

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

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

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

- The 18-month period (24 months if continuation is elected on or after 12/10/2004) beginning on the first date of your absence from work; or
- The day after the date on which you fail to apply for or return to a position of employment.

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

7 HOW TO OBTAIN COVERED SERVICES

Network Services and Benefits

If your care is rendered by a Network Provider benefits will be provided at the Network level. No benefits will be provided for care that is not a Covered Service even if performed by a Network Provider. The Employer has the final authority to determine whether the service is a Covered Service. The Administrator, on behalf of the Employer, will determine the benefits available according to the terms and provisions of this Benefit Booklet.

The Administrator, on behalf of the Employer, may inform you that a service you received is not covered under the Plan. You may appeal this decision. See the Complaint and Appeals Procedures section of this Benefit Booklet.

Network Providers include dentists and other professional Providers who contract with the Administrator or the Subcontractor to perform services for you.

For services rendered by Network Providers:

- You will not be required to file any claims for services you obtain directly from Network Providers. Network Providers will seek compensation for Covered Services rendered from the Plan and not from you except for approved Copayments and/or Deductibles. You may be billed by your Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this Plan.

If there is no Network Provider who is qualified to perform the treatment you require, the service may be obtained from a Non-Network provider, when approved by the Administrator, on behalf of the Employer.

Non-Network Services

Services which are not obtained from a Network Provider or a Plan approved Non-Network Provider, will be considered a Non-Network Service. In addition, certain services are not covered unless obtained from a Network Provider, see your Schedule of Benefits.

For services rendered by a Non-Network Provider, you are responsible for:

- The difference between the actual charge and the Maximum Allowable Amount plus any Deductible and/or Copayments
- Non-Covered Services
- Filing claims
- Higher cost sharing amounts

If a Non-Network Provider meets the Administrator's enrollment criteria and is willing to meet the terms and conditions of participation, that Provider has the right to become a Network Provider for the product associated with this Plan.

Choosing a Provider

Before choosing a dental care Provider, you may want to check your Provider directory. All Providers listed in the directory are Network Providers. If you do not have a current directory, contact a customer service representative for a complete list of Network Providers.

Although a directory is current as of the date published, it is subject to change without notice. To verify a Provider's current status with the Plan for this product, contact the Administrator's customer service

Your Provider choice, Network Provider or Non-Network Provider, can make a difference in the amount you pay.

Prior Carrier Authorizations for Pre-Existing Dental Conditions

If a Member who was previously covered under another dental plan received a Pretreatment Estimate, benefit authorization, or prior approval from the prior carrier, such authorizations will not be honored by the Plan. In these cases, to receive a Pretreatment Estimate, the Member should request that the Provider submit a Treatment Plan to the Administrator before services are received or completed (if the Member began treatment before changing to coverage under this Plan). Incomplete services that were begun before the Member's Effective Date that would otherwise be eligible for benefits may not be covered under this Plan. The Member should request that the Provider submit a Treatment Plan before the incomplete services are received or completed.

Relationship of Parties (Administrator - Network Providers)

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

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

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

Not Liable for Provider Acts or Omissions

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

Identification Card

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

8 COVERED SERVICES

This section describes the Covered Services available under your dental care benefits when provided and billed by Providers. All Covered Services are subject to the exclusions listed in the Exclusions section. The amount payable for Covered Services varies depending on whether you receive your care from a Network Provider or a Non-Network Provider.

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

If the Member and Dentist decide on a personalized restoration as opposed to a standard technique, benefit payment will be based on the Plan's Maximum Allowable Amount for the standard technique. The Member is solely responsible for the balance of charges.

The Maximum Allowable Amount for all Covered Services includes the administration of any necessary local anesthesia and the provision of necessary infection control procedures as required by state and federal mandates. If billed separately, such charges will be denied.

Diagnostic and Preventive Services

Diagnostic and preventive services are services that are used to avert dental disease or to

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

Oral Evaluation

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

Dental Radiographs (X-rays)

- **Bitewing radiographs** (up to four), limited to once per Benefit Period.
- **Complete series** (panoramic film or full-mouth radiographs), limited to once every three years. Complete series radiographs include bitewings, and will count as one occurrence for that Benefit Period. Nine or more radiographs in any combination of periapical and bitewing radiographs will be considered a complete series.

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

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

Cleaning, Scaling, and Polishing the Teeth (Prophylaxis)

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

Space Maintainers

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

Other Diagnostic and Preventive Services

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

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

General (Adjunctive) Services

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

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

- **Office visit for observation**, limited to two visits per Benefit Period (not covered when associated with other services or procedures).

Restorative Services

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

The following are covered restorative services under this Plan:

- **Amalgam restorations**, limited to once per surface per tooth in any Benefit Period.
- **Composite restorations**, limited to once per surface per tooth in any Benefit Period.
- **Pin retention**, limited to once per tooth in any Benefit Period (regardless of the number of pins per tooth). Pin retention must be performed on the same date of service and in conjunction with a covered amalgam or composite restoration.

Endodontic Services

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

Root Canal Therapy

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

Other Endodontic Services

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

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

Oral Surgery Services

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

- **Simple tooth extractions**
- **Surgical tooth extractions**
- **Alveoloplasty**
- **Vestibuloplasty**
- **Surgical Biopsy**

- **Excision of soft tissue lesions**
- **Excision of intra-osseous lesions**
- **Excision of bone tissue**
- **Frenulectomy**
- **Excision of hyperplastic tissue**
- **Surgical incision and drainage**

A biopsy report must be submitted with claims for the removal of tumors, cysts, or neoplasms.

Periodontal Services

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

Periodontal Surgical Services

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

Covered periodontal surgical services are:

- **Gingivectomy or gingivoplasty**, except when performed in conjunction with a crown build-up, post and core, or with a crown (the gingivectomy or gingivoplasty is considered part of that procedure and there will be no additional benefit).
- **Gingival flap procedure** (includes root planing)
- **Crown lengthening**, limited to once per tooth per lifetime.
- **Osseous surgery**, including flap entry with closure, limited to one osseous surgery per quadrant per Member in any three years. Benefits are available for a particular quadrant only for treated teeth having 5-mm pockets or more.
- **Osseous grafts** are a Covered Service for replacement of bone loss due to periodontal disease. No benefit is available for Osseous Grafts done in conjunction with extraction sites, ridge augmentation, or in preparation for the placement of implants.
- **Soft tissue grafts** - The Maximum Allowable Amount for a soft tissue graft includes removal of tissue from a donor site and a single graft for one tooth or a single draft covering two adjacent teeth. No additional benefit is available when removal of the donor tissue is billed separately from the soft tissue graft or a single graft for two adjacent teeth are billed separately.
- **Distal or proximal wedge procedure** is a Covered Service only when a periodontal pocket exists and the periodontal pocket measures 5mm or more. No additional benefit for the distal or proximal wedge procedure is available when periodontal surgery is performed in the same anatomical site and the distal or proximal wedge is billed separately.

Other (Adjunctive) Periodontal Services

Covered adjunctive periodontal services are:

- **Full-mouth debridement** to enable comprehensive periodontal evaluation and diagnosis (removal of subgingival and/or supragingival plaque and calculus), limited to a lifetime maximum of once per Member.
- **Periodontal scaling and root planing** if following osseous surgery or gingival flap procedure; however, six months must elapse between the time of osseous surgery or the gingival flap procedure, and the periodontal scaling and root planing. Periodontal scaling and root planing are limited to once per quadrant in any Benefit Period.

- **Periodontal maintenance procedures** only when following active periodontal therapy, limited to two cleanings per Benefit Period, whether routine or for periodontal maintenance.
- **Occlusal adjustment** (complete or limited) and **Occlusal guards** only if performed with osseous surgery or following osseous surgery received within the previous 12 months, limited to once in any three Benefit Periods.
- **Provisional splinting** (intracoronal or extracoronal) only if performed with osseous surgery or following osseous surgery received within the previous 12 months, limited to once in any three Benefit Periods.

Prosthodontic Services

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

Bridge

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

Crown

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

Denture

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

Crowns/Onlays

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

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

Other Covered Services related to crowns/onlays are:

- **Recementing of crowns/onlays**, limited to a lifetime maximum of once per crown/onlay.
- **Crown buildups** (includes pin retention), limited to once per tooth in any five benefit years (whether placement was under this product or under a prior dental coverage).

  Amalgam and/or composite restorations submitted in conjunction with crown buildups or post and core procedures will be considered as part of those procedures. Crown buildups performed in conjunction with post and core procedures will be considered part of those procedures. Crown buildups on the same tooth as an amalgam or composite restoration done within the same Benefit Period will not be covered.
- **Post and core buildups**, limited to once per tooth in any five years (documentation must be supplied to verify completion of root canal therapy).
- **Crown/onlay repairs**, limited to once per crown/onlay in any five years.
- **Stainless steel crowns** (for deciduous teeth only) Benefits are not provided for stainless steel crowns when used as a temporary crown.

Prosthodontics, Fixed

Fixed bridges are covered only when:

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

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

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

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

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

Prosthodontics, Removable

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

- **Removable complete immediate or permanent and partial dentures**, but only if the tooth/teeth being replaced were functional and extracted after the Member's Effective Date, limited to once in five years. Benefits are available for the replacement of complete or partial dentures, but only if the Appliance is five years old or older and either cannot be made serviceable or has been lost or stolen.

Covered Services for both complete and partial dentures include:

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

Orthodontic Services

Non-surgical dental services related to the supervision, guidance, and correction of growing or mature teeth. Covered Services include examination records, tooth guidance, and repositioning (straightening) of the teeth, as listed below.

Orthodontic benefits are paid on a quarterly basis and payment is made over the course of treatment, up to the maximum lifetime orthodontic benefit shown in the Schedule of Benefits, subject to the Maximum Allowable Amount. Orthodontic services are not subject to the annual benefit limit. **Refer to the Schedule of Benefits for orthodontic age limitations, applicable co-payments, deductibles (if any) and lifetime maximums for each eligible Member.**

The following are covered orthodontic services under this Plan:

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

Pretreatment Estimates and Treatment Plans

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

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

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

9 EXCLUSIONS

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

The Plan does not provide benefits for services or supplies:

1. Received from an individual or entity that is

not a Provider, as defined in this Benefit Booklet.

2. Procedures not yet recognized by the American Dental Association as indicated with a specific procedure code designation.
3. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
4. To the extent that they are provided as benefits through any governmental unit (except Medicaid), unless otherwise required by law or regulation. The payment of benefits under this Plan will be coordinated with such governmental units to the extent required under existing state or Federal laws.
5. For illness or injury that occurs as a result of any act of war, declared or undeclared;
6. For treatment of injuries sustained or illnesses resulting from participation in a riot or civil disturbance, or while committing or attempting to commit an assault or felony, unless otherwise required by law. Services, supplies or other care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs.
7. For court ordered care, unless authorized by the Administrator, on behalf of the Employer.
8. For which you have no legal obligation to pay in the absence of this or like coverage.
9. For any Pre-Existing Condition for the time period specified in the Schedule of Benefits.
10. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
11. Received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
12. For completion of claim forms or charges for medical/dental records or reports unless otherwise required by law.
13. For missed or canceled appointments.
14. Charges in excess of the Maximum Allowable Amount.
15. Incurred prior to your Effective Date.
16. Incurred after the termination date of this coverage except as specified elsewhere in this Benefit Booklet.
17. Primarily for educational, vocational, or training purposes, except as otherwise specified herein.
18. For any duplicate prosthetic device or other Appliance, or for a "spare" set of dentures or any other duplicate Appliance such as, but not limited to, removable orthodontic retaining devices.
19. For analgesics (includes nitrous oxide).
20. For athletic mouth guards.
21. For bacteriological studies for determination of pathologic agents.
22. For behavior management.
23. For bleaching of discolored teeth.
24. For canal preparation and fitting of prefabricated dowel and post.
25. For caries susceptibility tests.
26. For chemical treatments.
27. For crown buildups on the same tooth as an amalgam or composite restoration that was done within the same Benefit Period.
28. For procedures to restore occlusion vertical dimension or incisal edges due to bruxism, attrition or harmful habits.

29. For desensitizing medicaments and/or their application.
30. For diagnostic photographs, casts, or models.
31. For dietary instructions.
32. For discing.
33. Related to temporomandibular joint (TMJ) dysfunction, therapy or surgery, regardless of the reason(s) such services are necessary.
34. For enamel microabrasion.
35. For fixed bridge when done in conjunction with a removable Appliance in the same arch.
36. For procedures performed in the absence of dental or gingival disease, except for covered preventive and diagnostic care or Orthodontic Services.
37. For grafts to improve aesthetics.
38. For grafts to prepare for or that are associated with implants.
39. For gold foil restorations;
40. For guided tissue regeneration.
41. For histopathological examinations.
42. For house/hospital calls.
43. For implants and services or supplies, such as bridges, grafts, or dentures, that are provided in conjunction with implants.
44. For inlays and recementing of inlays.
45. For local anesthetic when billed separately.
46. For localized delivery of chemotherapeutic agents.
47. For occlusal analysis.
48. For oral hygiene instructions.
49. For OSHA fees and/or infection control fees when billed separately.
50. For osseous grafts if the following procedures have been performed on the affected tooth or site on the same date of service or within the previous 12 months:
    - Apicoectomy
    - Extraction
    - Hemisection
    - Retrograde filling
    - Root amputation
    - Root canal therapy
51. For post removal.
52. For precision attachments for partials and/or dentures.
53. For prefabricated resin crown or stainless steel crown with resin window.
54. For prescription drugs.
55. For pulp capping (direct or indirect).
56. For pulp vitality tests.
57. For pulpotomy on permanent teeth.
58. For rebonding of a Maryland bridge.
59. For recontouring.
60. For removable unilateral partial denture.
61. For replacement of a prosthodontic Appliance (fixed or removable) more often than once in any five-year period (measured from the date on which the replaced Appliance was last prepared for the Member, whether under this Plan or under any prior dental coverage).
62. For replacement of restorations due to mercury or other possible allergies.
63. For replacement of serviceable prosthodontics (services needed to make an Appliance serviceable will be provided in accordance with this Plan).
64. For resin crowns/onlays whether for single restorations, bridge retainers, or pontics.

65. For restorations on the same tooth as a previously placed sealant if fewer than two years have elapsed since the time sealants were placed.
66. For root canal therapy on deciduous teeth.
67. For sealants on restored teeth (occlusal surface).
68. For second professional opinions.
69. For sedative fillings.
70. For silicate restorations.
71. For stress breakers.
72. For temporary/interim prosthodontia or appliances (temporary crowns, bridges, partials, dentures, etc.).
73. For therapeutic injections.
74. For tissue conditioning procedures.
75. For tobacco-use counseling.
76. For upgrading of serviceable dentistry.
77. For two similar services performed at the same time where one service is an intergral part of a more extensive procedure.
78. For prosthetic devices to replace teeth missing (congenitally or otherwise) lost or extracted before the Member's Effective Date.
79. For mucogingival surgery.
80. Facility charges such as charges billed by a hospital inpatient or outpatient or by an ambulatory surgical center or day surgery center.
81. For services or supplies not specifically listed in this Benefit Booklet.

10 CLAIMS PAYMENT

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. Therefore, provisions below regarding "Claim Forms" and "Notice of Claim" do not apply, unless the claim was not filed by the Provider.

For services received from a Non-Network Provider, you are responsible for making sure a claim is filed in order to receive benefits. Many Providers, who are Non-Network Providers, will submit your claim for you. If you submit the claim use a claim form.

Maximum Allowed Amount

General

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

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

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

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Non-Network Dentist, you may be responsible for paying any difference between the Maximum Allowed

Amount and the Dentist's actual charges. This amount can be significant.

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

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

Provider Network Status

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

Network Dentist

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

Non-Network Dentist

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

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

1. An amount based on the Administrator 's Non-Participating provider fee schedule/rate, which the Administrator has established in its discretion, and which the Administrator reserves the right to modify from time to time, after considering one or more of the following: record fee data, reimbursement amounts accepted by like/similar providers contracted with the Administrator , reimbursement amounts accepted by like/similar providers for the same services or supplies, or other industry cost, reimbursement and utilization data; or
2. An amount based on information provided by a third party vendor which may reflect comparable Providers' fees and costs to deliver care; or
3. An amount negotiated by the Administrator or a third party vendor which has been agreed to by the Network Provider; or

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

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

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

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

Member Cost Share

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

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

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

Payment of Benefits

You authorize the Administrator, on behalf of the Employer, to make payments directly to Providers for Covered Services. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by the Administrator, on behalf of the Employer, will discharge the Employer's obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone else, or any applicable state law.

Once a Provider performs a Covered Service, the Administrator, on behalf of the Employer, will not honor a request to withhold payment of the claims submitted.

Assignment

The coverage and any benefits under the Plan are not assignable by any Member without the

written consent of the Administrator, except as described in this Benefit Booklet.

Notice of Claim

The Employer is not liable to pay benefits unless the Administrator, on behalf of the Employer, receives written notice that Covered Services have been given to you. An expense is considered incurred on the date the service or supply was given.

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

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

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, send a written request for claim forms to the Administrator or contact customer service and ask for claim forms to be sent to you. If you do not receive the forms, written notice of services rendered may be submitted to the Administrator or the Subcontractor without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient
- Patient's relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the Physician's signature
- Name of Subscriber

Member's Cooperation

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

Explanation of Benefits

After you receive dental care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement sent by the Administrator, on behalf of the Employer, to help you understand the coverage you are receiving. The EOB shows:

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

11 GENERAL PROVISIONS

Entire Agreement

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

Form or Content of Benefit Booklet

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

Disagreement with Recommended Treatment

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

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

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Administrator, 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 Administrator, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of dental care services payable by the Employer is delayed or rendered impractical, the Administrator, on behalf of the Employer, shall make a good-faith effort to arrange for an alternative method of administering benefits. In such event, the Administrator and Network Providers shall render dental care services provided under this Plan insofar as practical, and according to their best judgment; but the Administrator and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Coordination of Benefits

Applicability

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

If this provision applies, the Order of Benefit Determination Rules specify whether the benefits

of this Plan are determined before or after those of another Plan. The benefits of this Plan:

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

Definitions

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

1. Group insurance or group-type coverage whether insured or uninsured. This includes prepayment group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Individual insurance for individual-type coverage. This includes prepayment, group practice, or individual practice coverage.
3. Coverage under a governmental Plan or coverage required or provided by law except Medicaid.
4. Any other coverage which, as defined by the Employee Retirement Income Security Act of 1974, is a labor-management trustee Plan, a union welfare Plan, an employee organization Plan or an employee benefit organization.
5. Any other coverage provided because of sponsorship by or membership in any other association, union, or similar organization.

"Plan" is not any of the following:

1. Group or group-type Hospital indemnity benefits of $100.00 per day or less.
2. School accident-type coverage for grammar, high school, and college students for accidents only, including athletic injuries, either on a 24 hour basis or on a "to and from" school basis.

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

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

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

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

Allowable Expense - a dental care service or expense including Deductibles, coinsurance or Copayment, that is covered in full or in part by any of the plans covering the person.

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

Claim Determination Period - means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

Benefit Reserve - means the savings recorded by a Plan for claims paid for a Member as a Secondary Plan rather than as a Primary Plan.

Order of Benefit Determination Rules

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

1. The other Plan has rules coordinating its benefits with those of this Plan; and

2. Both those rules and this Plan's rules require that this Plan's benefits be determined before those of the other Plan.

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

1. Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, or Subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent.
2. Dependent Child/Parents not Separated or Divorced. Except as stated in paragraph 3. below, when this Plan and another Plan cover the same child as a Dependent of different parents who are not separated or divorced:
    a. The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; if (1) the parents are married; (2) the parents are not separated (whether or not they ever have been married); or (3) a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage; but
    b. If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.
3. Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
    a. First, the Plan of the parent with custody of the child;
    b. Then, the Plan of the spouse of the parent with custody of the child;
    c. Then, the Plan of the parent not having custody of the child; and
    d. Finally, the Plan of the spouse of the non-custodial parent.

    However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the Plan has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent will be the Secondary Plan. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's Plan is primary. This subclause does not apply to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has actual knowledge.
4. Joint Custody. If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the Order of Benefit Determination Rules outlined in paragraph 2.
5. Active/Inactive Subscriber. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired or as that employee's Dependent are determined before those of a Plan which covers that person as a laid off or retired employee or as that employee's Dependent. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule 5 is ignored. This rule does not supersede rule 1 above.
6. Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:
    a. First, the benefits of a Plan covering the person as an employee, or Subscriber or as that person's Dependent;

b. Second, the benefits under the continuation coverage. If the other Plan does not have the rule described above and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

7. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered the person longer are determined before those of the Plan which covered that person for the shorter term. If none of the preceding rules determines the Primary Plan, the Allowable Expenses shall be shared equally between the Plans.

Effect on this Plan's Benefits

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

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

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

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan. If this Plan is secondary, any Benefit Reserve accumulated for a Member will be used to pay Allowable Expenses of that Member only, not otherwise paid during the Claim Determination Period. The Benefit Reserve, if any, will return to zero at the end of the Claim Determination Period.

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

If the amount of the payment made by the Plan is more than it should have paid under this provision, it may recover the excess from one of more of:

1. The persons it has paid or for whom it has paid;
2. Insurance companies; or
3. Other organizations.

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

Physical Examination

The Administrator, on behalf of the Employer, reserves the right to cause you to be examined by an applicable Provider as often as may be reasonably required during the pendency of a claim.

Worker's Compensation

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

Other Government Programs

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

Subrogation and Right of Reimbursement

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

Subrogation

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

- The Administrator, on behalf of the Employer, has the first priority for the full amount of benefits they have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable the Administrator, on behalf of the Employer, to exercise their rights and do nothing to prejudice them.
- The Administrator, on behalf of the Employer, has the right to take whatever legal action they see fit against any party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Administrator's subrogation claim and any claim still held by you. The Administrator's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- The Administrator, on behalf of the Employer, is not responsible for any attorney fees, other expenses or costs without its prior written consent. The Administrator, on behalf of the Employer, further agrees that the "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Administrator, on behalf of the Employer.

Reimbursement

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

repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

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

Your Duties

- You must notify the Administrator promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with the Administrator in the investigation, settlement and protection of the Employer's and/or Administrator's rights.
- You must not do anything to prejudice the rights of the Administrator and/or the Employer.
- You must send the Administrator copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.

- You must promptly notify the Administrator if you retain an attorney or if a lawsuit is filed on your behalf.

Right of Recovery

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

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

Relationship of Parties (Employer-Member-Administrator)

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

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

Anthem Health Plans of Kentucky, Inc. Note

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

Notice

Any notice given under the Plan shall be in writing. The notices shall be sent to: The Employer at its principal place of business; to you at the Subscriber's address as it appears on the records or in care of the Employer; and Anthem Blue Cross and Blue Shield at P.O. Box 37690, Louisville, Kentucky 40233-7690

Modifications

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

Conformity with Law

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

Clerical Error

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

Policies and Procedures

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

Waiver

No agent or other person, except an authorized officer of the Employer, has authority to waive any conditions or restrictions of the Plan, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Employer's Sole Discretion

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

Reservation of Discretionary Authority

The Employer, or anyone acting on behalf of the Employer, 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, the Employer, or anyone acting on behalf of the Employer, has complete discretion to determine the administration of your benefits. The Employer's determination shall be final and conclusive. However, a Member may utilize all applicable member grievance procedures and Complaint and Appeals Procedures.

The Employer, or anyone acting on behalf of the Employer, 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 Plan. This includes, without limitation, the power to construe the Administrative Services Agreement, to determine all questions arising under the Benefit Booklet, to resolve Complaints 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 Benefit Booklet. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Administrative Services Agreement, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

12 COMPLAINT AND APPEALS PROCEDURES

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

- Your coverage and benefit levels, including Copayment amounts;
- Specific claims or services you have received;
- Providers in the Network, and/or
- Provider directories.

You will be notified, in writing, if a claim or other request for benefits is denied in whole or in part. If such a request is denied, the notice of denial will explain why benefits were denied and describe your rights under the Appeals Procedure. A Complaint Procedure also exists to help you understand the determinations made by the Administrator, on behalf of the Employer.

The Complaint Procedure

A Complaint Procedure is available to provide reasonable, informative responses to complaints that you may have concerning the Plan. A complaint is an expression of dissatisfaction that can often be resolved by an explanation of the procedures and contracts. The Administrator invites you to share any concerns that you may have over benefit determinations, coverage cancellations, or the quality of care rendered by Dental Providers in the Administrator's Networks.

If you have a complaint or problem concerning benefits or services, please contact the Administrator. Please refer to your Identification Card for the address and telephone number. You may submit your complaint by letter or by telephone call. Or, if you wish, you may discuss your complaint with the Employer.

Members are encouraged to file complaints within 60 days of an initial, adverse action, but must file within six months after receipt of notice of the initial, adverse action. The time required to review complaints does not extend the time in which appeals must be filed.

The Appeals Procedure

An appeal is a formal request from you for the Administrator, on behalf of the Employer, to change a previous determination. If you are notified in writing of a Coverage Denial or any other adverse decision by the Administrator, you will be advised of your right to an internal appeal.

A Coverage Denial means the Administrator's determination that a service, treatment, drug or device is specifically limited or excluded under this Benefit Booklet.

The internal appeals process may be initiated by the Member, the Member's authorized representative, or a Provider acting on behalf of the Member within 60 days of receipt of the Administrator's written notice of a Coverage Denial, or any other adverse decision made by the Administrator, but must be filed within six months of your receipt of the initial decision. The request should include any medical information pertinent to the appeal. All portions of the medical records that are relevant to the appeal and any other comments, documents, records or other information submitted by the Member relating to the issue being appealed, regardless of whether such information was considered in making the initial decision, will be considered in the review of the appeal. Any new medical information pertinent to the appeal will also be considered. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the Member's appeal.

If a representative is seeking an appeal on behalf of a Member, the Administrator must obtain a signed Designation of Representation (DOR) form from the Member. The appeal process

will not begin until Anthem has received the properly completed DOR. The Administrator will forward a Designation of Representation form to the Member for completion.

The individuals responsible for reviewing your request for an internal appeal will not be the same individuals who made the initial denial or determination. They will not be the subordinates of the initial decision maker either and no deference will be given to the initial decision.

Within a reasonable period of time but no later than 30 days after receiving a written or an oral request for an appeal, the Administrator will send a written decision to the Member or their authorized representative.

Contact Person For Appeals

The request for an internal appeal must be submitted to the following address or telephone number or to the appeal address or telephone number provided on your written notice of an adverse decision:

Contact: Anthem Blue Cross and Blue Shield
Position: Appeals Department
Address: P. O. Box 659471
San Antonio, TX 78265-9471

The person holding the position named above will be responsible for processing your request.

The Administrator encourages its Members to submit requests for appeal in writing. The request for appeal should describe the problem in detail. Attach copies of bills, medical records, or other appropriate documentation to support the appeal that may be in your possession.

You must file appeals on a timely basis. As stated above, you are encouraged to file internal appeals within 60 days of your receipt of the Administrator's initial decision. Internal appeals must be filed, however, within six months of your receipt of the initial decision.

Dental Services

The Administrator is not liable for the furnishing of Covered Services, but merely for the administration of them. You shall have no claim against the Administrator and/or the Subcontractor for acts or omissions of any Provider from whom you receive Covered Services. The Administrator and/or the Subcontractor has no responsibility for a Provider's failure or refusal to give Covered Services to you.

Limitation of Actions

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced no earlier than 60 days after the Administrator receives the claim or other request for benefits and within three years of the Administrator's final decision on the claim or other request for benefits. If the Administrator decides an appeal is untimely, the Administrator's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Administrator's internal appeals procedure before filing a lawsuit or other legal action of any kind against the Administrator. If your dental benefit plan is sponsored by your employer and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action.

Get help in your language

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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