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Dunn County Employees

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Dental benefits underwritten by Blue Cross Blue Shield of Wisconsin

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Underwritten by Blue Cross Blue Shield of Wisconsin



Dental benefits underwritten by Blue Cross Blue Shield of Wisconsin

Your Dental Certificate

Dental Certificate of Coverage

WI Dental Care Indemnity BENEFIT HANDBOOK

We settle claims based upon varying methodologies, which may be less than the provider's billed charge. Please see page D-25 in the General Provisions section of this Booklet for more details.

Important Notice Regarding Statements In The Enrollment Form For Your Insurance

Please review the copy of the enrollment form you completed when applying for coverage. Omissions or misstatements in the enrollment form could cause an otherwise valid claim to be denied. Carefully check the enrollment form and write to Us within ten (10) days if any information in the form is incorrect or if any information is missing.

Please direct Enrollment Information to:

Anthem Blue Cross and Blue Shield

P.O. Box 659444

San Antonio, TX 78265-9444

1-866-589-0582

Please Direct Correspondence, Claims & Grievances To:

Anthem Blue Cross and Blue Shield

Attn: Appeals Department

P.O. Box 659471

San Antonio, TX 78265-9471

Blue Cross Blue Shield of Wisconsin dba Anthem Blue Cross and Blue Shield

N17 W24340 Riverwood Drive

Waukesha, WI 53188

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1 GENERAL INFORMATION

We hope this booklet will become an important tool in helping you interpret the benefits you now enjoy as a Member. We have tried to outline your dental coverage in a straightforward manner, using plain language. This booklet defines many words that are common in the dental insurance industry. However, this booklet is not the Contract. In a conflict between Contract and booklet language, the Contract language controls.

IDENTIFICATION CARDS

We give you an Identification Card. It ends most red tape and claim procedures. Show your card to

the Dentist when requesting services.

INFORMATION

Though we have tried to make this booklet as detailed as possible, you may still have questions about your coverage or membership. When you do, write or call Center Customer Service at the phone and/or address listed below.

Anthem Blue Cross and Blue Shield
P.O. Box 659444
San Antonio, TX 78265-9444
1-866-589-0582

2 SCHEDULE OF BENEFITS

DENTAL INSURANCE COVERAGE

ELIGIBLE GROUP MEMBERS

To be eligible for coverage, You must be a regular full-time employee (not part-time, seasonal or temporary), a partner, or a sole proprietor. You must also: (1) actively perform the duties of Your principal occupation for at least thirty (30) hours per week; (2) satisfy any Probationary Period that applies to You; and (3) be eligible for all the fringe benefits which apply to the class of employees to which You belong.

EFFECTIVE DATE

The first day of the month after You complete Your Probationary Period and We approve Your application for coverage.

DEDUCTIBLE

Not Applicable

MAXIMUM BENEFITS

1. \$1,000 aggregate maximum per Calendar Year per Member.
Applies to all Dental Services other than orthodontic services.

2. Orthodontic Maximum
\$800 per Dependent child Member's lifetime.

LEVEL OF BENEFITS

All benefits are based on our Maximum Allowed Amount. Please see the section "How Maximum Allowed Amount is Determined" for more details.

A. Diagnostic

1. Dental Radiographs
 - 100%
 - 1 full mouth X-ray series in a period of 36 months in a row
 - 1 supplementary bitewing X-ray series, limited to 2 in a calendar year
 - We cover Panoramic X-rays or a full mouth series of X-rays, but not both
2. Routine Oral Examinations and Prophylaxes
 - 100%
 - 1 oral exam or prophylaxis, limited to a total of 2 in a calendar year

B. Preventive

1. Topical Fluoride Treatment
 - 100%
 - limited to Members under age 19 years
2. Space Maintainers
 - 100%
 - limited to Members under age 19 years
3. Sealants
 - 100%
 - limited to Members under age 13 years

C. Ancillary

1. General Anesthesia
 - 100%
2. Antibiotic Drugs
 - 100%
3. Emergency Palliative Care
 - 100%

4. Emergency Denture Repairs and Adjustments
 - 100%

D. Restorative

1. Direct Filling Procedures
 - 100%
2. Indirect Filling Procedures
 - Not a Benefit

E. Oral Surgery

- 100%

F. Endodontics

- 100%

G. Periodontics

- 100%

H. Prosthodontics

- 50%

I. Orthodontics

- 50%

- limited to Dependent children Members under age 19 years

3 GENERAL DEFINITIONS

When used and capitalized in this booklet, these terms have the following definitions:

ACTIVELY AT WORK/ACTIVE WORK means You are regularly performing the duties of Your principal occupation for Your regularly scheduled number of hours at Your usual place of business.

CALENDAR YEAR means January 1 through December 31 of each year.

COINSURANCE means a portion of the Maximum Allowed Amount for Dental Services for which You are responsible. Coinsurance will not be reduced by refunds, rebates, or any other form of negotiated post-payment adjustments.

CONTRACT means the written agreement that defines the benefits, terms, and conditions of coverage.

CONTRACT EFFECTIVE DATE means the

date on which coverage under the Contract begins for the Group. It is shown on the Contract's face page.

CONTRACT TERMINATION DATE means the date on which the Contract terminates.

DEDUCTIBLE means a specified amount for each Dental Service, usually expressed in dollars. You must incur the Deductible before We assume any liability for all or part of the remaining Dental Services.

DENTAL SERVICE means a service or supply for which We provide benefits. You incur a charge for a Dental Service on the date the service or supply is provided to You. Dental Service does not include any service or supply if the provision of that service or supply is not documented in provider records.

DENTIST means a licensed Doctor of Dental Surgery or equivalent as recognized by the American Dental Association. Dentist includes any other professional practitioner authorized by law to practice dentistry at the time and place dental services are performed.

DEPENDENT means a Member other than You, the Subscriber. Please refer to DEPENDENT ELIGIBILITY.

EFFECTIVE DATE means the date on which a person's coverage under this Contract begins.

EXPEDITED GRIEVANCE means a Grievance which requires immediate consideration and involves any of the following circumstances:

1. Serious jeopardy to the life or health of the Member or the ability of the Member to regain maximum function;
2. A situation where, in the opinion of a Dentist with knowledge of the Member's condition, the Member would be subjected to severe pain that cannot be adequately managed without the service or treatment that is the subject of the grievance.
3. It is determined by a Dentist with knowledge of the Member's dental condition that an Expedited Grievance exists.

EXPERIMENTAL/INVESTIGATIONAL means procedures not yet recognized by the

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

Decisions made to deny or limit dental treatment based on an Experimental/Investigational basis are made by a licensed Dentist or any other professional practitioner licensed to practice dentistry. In the event You disagree with this or any decision you have the right to file a written Grievance. You will find details on how to do this in the General Provisions section of this booklet. You may also contact Our customer service number on your ID card.

A request for pre-treatment determination may be submitted in writing to the Us. If prior written approval for a treatment or service is provided, benefits will be paid if the Member's coverage is in force and if the approval has not expired at the time such treatment or service is provided.

FAMILY COVERAGE means coverage for You, the Subscriber, and one or more of Your Dependents.

GRIEVANCE means a written complaint that You, or someone on Your behalf, files with Us. The Grievance may involve Your dissatisfaction with Our administration or claims practices, the provision of services, denial of services, or limitations based on Experimental / Investigational treatment.

GROUP means the employer or organization through which You have this coverage.

INJURY means bodily damage that results directly and independently of all other causes from an accident.

MAXIMUM ALLOWED AMOUNT means the maximum amount of reimbursement We will allow for Dental Services under the plan, as outlined in the "How Maximum Allowed Amount is Determined" section of this Booklet.

MEDICALLY NECESSARY (MEDICAL NECESSITY) - Medically Necessary procedures, services, or treatments are those that are:

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

MEMBER means You, the Subscriber. If You have Family Coverage, Member includes Your Dependents.

ORTHOGNATHIC SURGERY means a surgery designed to reposition the maxilla (upper jaw bone) and/or mandible (lower jaw bone). Its purpose is to achieve harmony in function and appearance between the jaws.

OSTEOTOMY means a type of Orthognathic Surgery which involves a surgical incision into the maxilla (upper jaw bone) and/or mandible (lower jaw bone). An Osteotomy may be classified as a Sagittal Split, a Segmental Osteotomy, a Subcondylar Osteotomy, and/or a Vertical Osteotomy.

PROBATIONARY PERIOD means the continuous length of time an employee must be employed with the Group before he or she is eligible for coverage under this Contract. The Probationary Period is shown in the Group Application.

SUBSCRIBER means a member of the Group who:

1. Meets the Group's eligibility requirements for fringe benefits;
2. Meets the Contract's eligibility requirements;
3. Has applied and been accepted by Us for coverage under the Contract; and
4. Has caused premium payment to be made on his or her behalf.

TREATMENT PLAN means a written report prepared by a Dentist, which shows the proposed treatment for Your dental disease, defect, or Injury. A Treatment Plan shows all necessary procedures, the series of visits, and the charges for the treatment.

WE, US, AND OUR means BLUE CROSS BLUE SHIELD OF WISCONSIN dba Anthem Blue Cross and Blue Shield, which provides benefits to Members for the Covered Services described in this Booklet.

YOU AND YOUR means any Member, unless the booklet language refers specifically to the Subscriber or a Dependent.

4 ELIGIBILITY

In this Section, "You" and "Your" refer only to the Subscriber.

SUBSCRIBER ELIGIBILITY

The Schedule of Benefits shows the classes of people eligible for coverage under this Contract.

DEPENDENT ELIGIBILITY

A Dependent means and includes:

1. The legal spouse.
2. Your children. This includes legally adopted children and children for whom You are the legal guardian. Dependent includes Your step-children if Your spouse is responsible by decree of divorce for their medical insurance. Your child's eligibility ends:

- a. At the end of the month he or she reaches age 26. reaches age 18.
- b. Reaching the limiting age does not end the coverage of an unmarried Dependent child who is:

- Incapable of self-sustaining employment due to mental retardation or physical handicap; and chiefly dependent on You or Your spouse for support and maintenance. The incapacity and dependency must begin while the child is insured under this Contract. You must provide Us proof of the incapacity and dependency within 31 days of the child's reaching the limiting age. Then You must provide proof as often as We require. This will not be more often than once a year after the 2 year period following the child's reaching the limiting age. You must provide the proof at no cost to Us.
- Called to active duty in the National Guard or in a reserve component of the United States armed forces prior to age 26 and is currently a full-time student, regardless of age. The Dependent child cannot be eligible for coverage under his/her employer's group health plan unless the premium for that coverage is greater than the premium charged for a Dependent under this Booklet. Coverage will end when the child ceases to be a full-time student, marries, or becomes eligible for a group health plan for which the premium is less than the premium charged a Dependent under this Booklet.

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

3. Your Dependent child's children (Your grandchildren) until Your Dependent child

COVERAGE OF DEPENDENT STUDENTS ON MEDICAL LEAVE

The information below applies to Dependent students who were called to active duty in the National Guard or in a reserve component of the United States armed forces prior to age 27 and have now returned to school on a full-time basis.

If, while covered under this Booklet, a Dependent student needs to reduce his/her course load or leave school due to a Medically Necessary leave of absence, the Dependent student may be eligible to continue coverage under this Booklet.

We may require documentation of the Medical Necessity of the leave of absence from the Dependent's attending Physician. The date on which the Dependent ceases to be a full-time student due to the Medically Necessary leave of absence shall be the date on which the continuation of coverage begins.

Coverage will continue until any of the following occurs:

- 1) We are advised that the Dependent does not intend to return to school full time.
- 2) The Dependent becomes employed full time.
- 3) The Dependent obtains other health care coverage.
- 4) The Dependent marries and is eligible for coverage under his or her spouse's health care coverage.
- 5) Coverage of the Member through whom the person has Dependent coverage under this Booklet is discontinued or not renewed.
- 6) One year has elapsed since the Dependent's continuation of coverage began and the Dependent has not returned to school full time.

APPLICATION

You should apply for coverage within 31 days of becoming eligible. If You have eligible Dependents, You may apply for Dependent coverage. You should do so within 31 days of the date Your Dependents first become eligible for coverage.

We will reject Your application if You apply for coverage more than 31 days after You first become eligible unless:

1. At the time You apply for this coverage, You also complete and send to Us an application and evidence of insurability form for You and Your Dependents, applying for hospital and/or surgical-medical coverage through the Group. If We approve that application and evidence of insurability, We will also accept Your application for this coverage; or
2. You apply for this coverage within 30 days of losing eligibility under another dental plan (or within 60 days after Medicaid coverage ends).

EFFECTIVE DATE

The Effective Date is shown in the Schedule of Benefits.

If You apply for Your coverage and Your Dependent's coverage at the same time, You and Your Dependents will have the same Effective Date. A Dependent's Effective Date cannot be before Your Effective Date. However:

1. If You marry after Your coverage is effective, You should apply for Family Coverage within 31 days of Your marriage. If You do, Your Family Coverage becomes effective on the marriage date.
2. If Family Coverage is already in force, coverage for a newborn child begins on the date of birth. If additional premium is required for the newborn, it must be paid within 60 days of the birth; if the premium is not paid within that time, coverage for the newborn ends 60 days after birth. Within

one year of the birth, You may reinstate the newborn's coverage by paying all past due premium plus interest at the rate of 5 1/2% per year.

3. If You have Family Coverage and (1) You adopt a child, or (2) You have a child placed with You for adoption, or (3) You are named the legal guardian for a child, the Effective Date of coverage for that child is the earlier of:
 - a. the date of the final court order granting adoption; or
 - b. the date the child is placed in Your home.
 - c. You are required to notify Us of this and pay the additional premium, if any, within 60 days of the adoption, placement, or appointment.
4. In all other cases, We must approve Your application for Dependent coverage before Dependent coverage is effective.

You are not covered by the Contract until Your Effective Date. We will notify You of Your Effective Date when We send Your Identification Card.

Unless the Benefit Provisions state otherwise, on the day Your coverage is to become effective, You must be Actively At Work. A day of vacation or a holiday is considered Active Work if You are able to do Active Work on that day.

BADGERCARE

If the Wisconsin Department of Health and Family Services agrees to purchase coverage under this Booklet for you in lieu of enrolling you in the Medical Assistance Program (under s. 49.472, Wis. Stat.), Badger Care (under s. 49.665, Wis. Stat.), or BadgerCare Plus (under s. 49.471, Wis. Stat.), you will have 60 days from the date of that determination to apply for this coverage. If we receive your completed application within 60 days, We will enroll you on the first of the month following Our receipt of the application.

INDIVIDUAL REINSTATEMENTS

If coverage ends because Your employment terminates, the coverage may be reinstated when You return to Active Work.

If You return to Active Work within 90 days of Your termination date, coverage is effective on the date of return. We will not require evidence of insurability. Any waiting periods apply only to the extent they applied before termination. The benefits We reinstate are the benefits that You and Your Dependents would have received if coverage had been continuous. You must pay any premium required of You.

If You return to Active Work more than 90 days after Your termination date, We consider You to be a new eligible person. The APPLICATION and EFFECTIVE DATE provisions apply.

If You request reinstatement for a reason other than return to Active Work, We require evidence of insurability. We will specify the terms and effective date for the reinstatement.

If you return to Active Work upon the completion of an FMLA leave period and you elect to have coverage reinstated or the Group requires your coverage be reinstated, coverage will be reinstated on the date you return from FMLA leave. The benefits We reinstate are the benefits that you and your Dependents would have received if coverage had been continuous.

Following a military leave, if you return or request re-employment within the statutory period, coverage will be reinstated on the date you return. If you had converted your coverage, your conversion policy ends on the day We reinstate this coverage.

BENEFIT ELECTIONS

You may elect coverage under this Contract only in accordance with the ELIGIBILITY terms and conditions. However, if this Contract is part of a Section 125 cafeteria plan, You may:

1. Revoke Your benefit election regarding this Contract; and
2. Make a new election for the remainder of the coverage period.

You may do this only if both the revocation and new election are due to and consistent with a change in family status. These changes include:

1. Marriage or divorce;
2. Death of Your spouse or child;
3. Birth or adoption of a child;
4. Termination or commencement of employment of Your spouse;
5. Change in employment status of either You or Your spouse from full-time to part-time or vice versa; or
6. The taking of an unpaid leave of absence by You or Your spouse.

You may also make an election change if there has been a significant change in the health coverage of You or Your spouse attributable to the spouse's employment.

COURT-ORDERED COVERAGE

If a court orders a Member to provide coverage for dental expenses for a child of the Member and the Member is eligible for Family Coverage under this Contract, We:

1. Provide Family Coverage under the Contract for the Member's child, if eligible for coverage, without regard to any enrollment period restrictions that may apply under the Contract;
2. Provide Family Coverage under the Contract for the Member's child, if eligible for coverage, upon application by the Member, the child's other parent, or the Department of Health and Family Services or the county designee under s. 59.07 (97); and
3. After the child is covered under the Contract, and as long as the Member is eligible for Family Coverage under the Contract, continue to provide coverage for the child unless We receive satisfactory

written evidence that the court order is no longer in effect or that the child has coverage under another group policy or individual policy that provides comparable dental coverage.

If We provide coverage under a Contract for a child of a Member who is not the custodial parent of the child, We shall do all of the following:

1. Provide to the custodial parent of the child information related to the child's enrollment;
2. Permit the custodial parent of the child, a dental provider that provides services to the child, or the Department of Health and Family Services to submit claims for Dental Services without the approval of the parent who is the Member; and
3. Pay claims directly to the dental provider, the custodial parent of the child, or the Department of Health and Family Services as appropriate.

5 DENTAL UTILIZATION REVIEW

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

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

Pre-Treatment Review

You may have a pre-treatment review done before you receive benefits. Pre-treatment review is not a prior authorization for services but is a system that allows You and Your Dentist to know, in advance, what the estimated benefits payable would be under this plan for a proposed course of

treatment. The actual benefits you receive under the plan will be determined once a claim for services has been received and may vary from the estimated benefits based upon the actual services received as well as the benefit coverage in effect on the date(s) of services.

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

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

Retrospective Review

Retrospective review means a Medical Necessity review that is conducted after dental care services have been provided. A claim review includes, but is not limited to, an evaluation of reimbursement levels, accuracy of documentation, accuracy of coding and adjudication of payment.

We provide a toll-free telephone number available during normal business hours to assist You or Your Dentist in obtaining information with respect to Our utilization review process. This same number may be utilized after business hours to leave a message which will be responded to within two business days in non-emergent situations.

If You disagree with a utilization review decision and wish to file a Grievance, or appeal a decision previously made You will find details on

how to do this in the General Provisions section of this booklet. You may also contact Our customer service number on your ID card.

The utilization review process is governed by laws and regulations, and may be modified from time to time by Us as those laws and regulations may require. A more detailed description of the decision making timeframes are set forth in Our utilization review guide. This guide is available by calling Customer Service at 800-627-0004.

6 DENTAL INSURANCE COVERAGE

INSURANCE PROVIDED

We will pay benefits up to the Maximum Allowed Amount You incur for Dental Services. Our payment is subject to the Contract terms and conditions. The Deductible that You pay, the level of benefit We pay, and the maximum benefit are shown in the Schedule of Benefits.

A. Diagnostic

1. Dental radiographs (x-rays). This includes full mouth, supplementary bitewing, and other dental radiographs required to diagnose a specific condition requiring treatment.

Diagnostic services include Panoramic Radiographs.

2. Routine oral examinations and adult or pediatric prophylaxis (scaling and cleaning of teeth).
 - a. Adult prophylaxis means the scaling and cleaning of teeth of Members age 13 and older.
 - b. Pediatric prophylaxis means the scaling and cleaning of teeth of Members age 12 years and under.

B. Preventive

1. Topical Fluoride Treatment.

2. Space maintainers that replace prematurely lost teeth.

3. Sealants.

B. Ancillary

1. General anesthetics when Medically Necessary and administered in connection with oral or dental surgery.
2. Injections of antibiotic drugs by the attending Dentist.
3. Emergency palliative care. Palliative care is care which relieves the symptoms of disease flare-up, but which does not result in an improvement of the patient's stationary condition.
4. Emergency denture repairs and adjustments other than:
 - a. Adjustments for the initial insertion of partial or full removable dentures; and
 - b. Adjustments during the 6-month period following initial insertion.

D. Restorative

Procedures necessary to eliminate oral disease.

1. Direct Filling Procedures

Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations of diseased or broken teeth.

2. Indirect Filling Procedures (Cast Restorations)

- a. Inlays, onlays, or crowns to restore diseased or broken teeth. We cover these only when Your tooth, as a result of extensive decay or fracture, cannot be restored by a direct filling procedure (amalgam, silicate, acrylic, synthetic porcelain or composite). If Your tooth can be restored with a direct filling procedure, but You and Your Dentist select another type of restoration, We pay the benefits that We would pay for direct filling procedures. The balance of the treatment charge is Your responsibility.
- b. Charges for veneers or similar properties of crowns and pontics placed on or replacing the 10 upper and lower most anterior (front) teeth.

E. Oral Surgery

Simple extractions, and the oral surgeries listed below are Dental Services. No other oral surgeries are covered by the Contract.

1. Surgical exposure or removal of impacted teeth and related necessary x-rays.
2. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when the conditions require a pathological examination.
3. Surgical procedures required to correct Injuries to the jaws, cheeks, lips, tongue, roof and floor of the mouth. You must incur the Injuries while covered under this Contract.

4. Apicoectomy - Excision of apex of tooth root.
5. Excision of exostoses of the jaws and hard palate.
6. Treatment of fractures of facial bones.
7. External incision and drainage of cellulitis.
8. Incision of accessory sinuses, salivary glands or ducts.
9. Reduction of dislocations of, and excision of, the Temporomandibular Joints (TMJ).
10. Gingivectomy - Excision of loose gum tissue to eliminate infection.
11. Alveolectomy - The leveling of structures supporting teeth for the purpose of fitting dentures.
12. Frenectomy - Incision of any midline fold of tissue between the jaws and lips and between the lower jaw and tongue.
13. Removal of retained (residual) root.
14. Gingival curettage under general anesthesia.
15. Apical curettage.

We do not pay benefits for these oral surgeries, if, when the surgery is performed, You are covered by a hospital and/or surgical-medical group policy We have issued that provides benefits for these services.

F. Endodontics

Pulpal and root canal therapy.

G. Periodontics

Treatment of the gums and supportive structures of the teeth.

H. Prosthodontics

1. Initial insertion of fixed bridges (including inlays and crowns as abutments).
2. Initial insertion of partial or full removable dentures (including any adjustments during the 6-month period following insertion), provided that:
 - a. For Partial Dentures
If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, but You and Your Dentist select a more elaborate or precision appliance, We pay the benefits that We would pay for the cast chrome or acrylic partial denture. The balance of the cost is Your responsibility.
 - b. For Complete Dentures
If You and Your Dentist decide on personalized restorations or specialized techniques instead of standard procedures, We pay the benefits that We would pay for the standard denture services. The balance of the cost is Your responsibility.
3. Replacement of an existing removable partial or full denture, or fixed bridge by a new removable partial or full denture, or fixed bridge; or the addition of teeth to an existing removable partial denture or to a bridge. You or Your Dentist must provide satisfactory evidence that:
 - a. The replacement of teeth or addition of teeth is required to replace one or more teeth extracted after the existing removable partial or bridge was inserted; or,
 - b. The existing denture or bridge was inserted at least 5 years before its replacement and the existing denture or bridge cannot be made serviceable; or,
 - c. The existing denture is an immediate temporary full denture which cannot be made permanent. Replacement by a permanent denture must take place

within 12 months from the date of the initial insertion of the immediate temporary full denture.

We cover the replacement of an existing denture only if the existing denture is unserviceable and cannot be made serviceable. We pay the benefit level which applies to the cost of services necessary to make the appliances serviceable. We cover replacement of prosthodontic appliances only if at least 5 years have elapsed since the date of the initial insertion of that appliance.

4. Double abutments are covered only when Medically Necessary.
5. Treatment partials are covered only when used as a space maintainer for Members under 19 years of age.

I. Orthodontics

1. Orthodontic diagnostic procedures and treatment consisting of surgical therapy and appliance therapy.
2. Method of Payment
We pay benefits for orthodontic services based on the approved Treatment Plan as follows:
 - a. We pay the initial fee at the time the appliance is first inserted. Our payment is either:
 - i. 25% of the total fee when services are not stated separately (Single Charge Basis); or
 - ii. 25% of the lesser of the total fee or the actual charge billed when services are stated separately (Case Fee Breakdown Basis).
 - b. Then, at the end of each quarter following the start of treatment, We pay equal amounts calculated on the balance of the Treatment Plan, less the initial fee paid, regardless of the services rendered during any such quarter that the Contract is in effect. This payment

formula is applied to any portion of the Treatment Plan that is carried out while the Contract is in effect. We do not pay for orthodontic benefits if the Member's coverage terminates, or if the Member attains the age limit for orthodontic services during a course of treatment.

3. If orthodontic treatment is terminated for

any reason before completion, Our obligation to pay benefits ends with the payment to the date of termination. If services are resumed, benefits for the services, to the extent remaining, resume.

4. Simple extractions required in connection with orthodontic procedures are covered under Oral Surgery.

7 GENERAL EXCLUSIONS

No benefits are available for:

1. Services, supplies, or equipment which:

- a. Are not specifically described as Dental Services; or
- b. Are furnished in connection with or as a result of a non-covered service, even though the services, supplies, or equipment would otherwise be Dental Services.

2. Services, supplies, or equipment furnished:

- a. Before the Member's Effective Date; or
- b. After the date the Member's coverage ends, except for:
 - i. Prosthetic devices which were ordered and fitted before, and completed within 60 days after, the date the Member's coverage ends; and
 - ii. Procedures, other than prosthetics, which were begun before, and completed in one visit within 31 days after, the date the Member's coverage ends.

3. Any portion of a charge which is more than the Maximum Allowed Amount.

4. Services, supplies, or equipment that are not Medically Necessary.

5. Services, supplies or equipment that are Experimental/ Investigational.

6. Dental Services provided by a Dentist who is a member of the Member's immediate family. Immediate family means the Subscriber's or Member's spouse, children, parents, grandparents, brothers and sisters and their spouses.

7. Dental Services rendered or furnished in connection with elective plans of treatment. To the extent that they are available, We provide benefits for the suitable plan carrying the lesser fee.

8. Dental Services for congenital malformations, or primarily for cosmetic or esthetic purposes. This exclusion applies to existing teeth, not to congenitally missing teeth.

9. Charges for:

- a. Any duplicate appliance or device;
- b. The replacement of a lost, stolen, or missing prosthetic device;
- c. The replacement or repair of an orthodontic appliance.

10. Charges for:

- a. Oral hygiene counseling and dietary instruction;
- b. Plaque control programs;
- c. Implantology;
- d. Splinting procedures.

11. Charges for Dental Services for which benefits are otherwise provided under Your surgical/medical or prescription drug coverage.
12. Precision attachments, precision partials, or treatment partials except as specified in the Contract.
13. Charges for veneers or similar properties of crowns and pontics placed on or replacing teeth other than the 10 upper and lower most anterior (front) teeth.
14. Appliances, restorations, or procedures needed to adjust vertical dimension or to restore occlusion, except as an integral part of comprehensive orthodontic treatment.
15. Orthodontic services until the Member has been covered by this Contract for 2 years in a row, if You, the Subscriber, did not enroll during Your first available enrollment period.
16. Orthognathic Surgery or Osteotomies.
17. Treatment of Temporomandibular Joint (TMJ) Disease other than recognized radical oral surgery for TMJ Disease. Neither Orthognathic Surgery nor Osteotomies are covered as treatment for TMJ Disease.
18. Dental Services for any illness or Injury:
 - a. Which occurs in the course of employment; and
 - b. For which You are eligible for compensation, in whole or in part, under any Worker's Compensation Act or Employer Liability Law.

This exclusion applies whether or not You:

 - a. Claim the benefits or compensation; or
 - b. Recover losses from a third party.
19. Dental Services resulting from an illness contracted or Injury sustained as a result of:
 - a. War, whether declared or undeclared; or
 - b. Service in the armed forces of any country or state.
20. Services, supplies, or equipment to the extent benefits are provided by any governmental unit.
21. Services, supplies, or equipment to the extent Medicare is Your primary payor, which it is, except where Medicare is secondary by law. Where Medicare is primary payor, no benefits are available for Dental Services:
 - a. For which You would have been entitled to Medicare benefits had You enrolled in Medicare or complied with Medicare requirements.
 - b. Which Medicare considers not reasonable or not medically necessary.
22. Free care, or care for which You would have no legal obligation to pay if You did not have this or any similar coverage.
23. Services, supplies, or equipment received from a dental or medical department maintained by or on behalf of a/an:
 - a. Employer;
 - b. Mutual benefit association;
 - c. Labor union;
 - d. Trust;
 - e. Academic institution;
 - f. Similar person or group.
24. The following charges:
 - a. Charges for failure to keep a scheduled visit;
 - b. Charges for completion of a claim form;
 - c. Charges which are not documented in provider records; or
 - d. Federal, state or local tax on goods or services.

8 HOW MAXIMUM ALLOWED AMOUNT IS DETERMINED

General

This section describes how We determine the amount of reimbursement for Dental Services. Reimbursement for dental services rendered by participating and non-participating 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 Our definition of Dental 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 plan.

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 Dental Services from a non-participating Dentist, you may be responsible for paying any difference between the Maximum Allowed Amount and the Dentist's actual charges. This amount can be significant.

When you receive Dental Services from a Dentist, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Dental Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the dental procedure. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Dental Services you received were not Medically Necessary. It means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your

Dentist may have submitted the claim using several procedure codes when there is a single procedure code that includes all or a combination of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

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

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the provider is a participating Dentist or a non-participating Dentist.

Participating Dentist

A participating Dentist is a Dentist who is in the contracted network for this specific plan or who has a participation contract with Us. For Dental Services performed by a participating Dentist, the Maximum Allowed Amount for your plan is the rate the Dentist has agreed with Us to accept as reimbursement for the Dental Services. Because participating Dentists have agreed to accept the Maximum Allowed Amount as payment in full for those Dental 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 participating Dentist or visit www.anthem.com.

Non-Participating Dentist

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

For Dental Services You receive from a non-participating Dentist, the Maximum Allowed Amount for this plan will be one of the following as determined by Us:

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

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

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

participating Dentist or visit Our website at www.anthem.com.

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

Member Cost Share

For certain Dental 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 participating or non-participating Dentist. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using non-participating Dentists. Please see the Schedule of Benefits 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.

We 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.

9 COORDINATION OF BENEFITS

APPLICABILITY

This Coordination of Benefits ("COB") provision applies to This Plan when You have dental care coverage under more than one Plan, except to the extent this provision is superseded by the Medicare secondary payor rules. "Plan" and "This Plan" are defined below.

If this COB provision applies, the order of benefit determination rules are looked at first. The rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

1. Are not 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. This reduction is described in EFFECT ON THE BENEFITS OF THIS PLAN.

DEFINITIONS

When used in this Section only, these terms have the following meanings.

ALLOWABLE EXPENSE means a necessary, reasonable, and customary item of expense for dental care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered is 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.

PLAN means any of the following, which provides benefits or services for, or because of,

dental care or treatment:

1. Group dental insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice, or individual practice dental coverage. It also includes dental coverage other than school accident-type coverage.
2. Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.
3. "No-fault" and group or group-type "fault" automobile insurance policies or contracts.

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

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 You.

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 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 there are more than two Plans covering You, 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.

THIS PLAN means the part of the Contract that provides benefits for dental care expenses.

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 You as an employee, member 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 rule 3, when This Plan and another Plan cover the same child as a Dependent of different persons (called "parents"):
 - a. The benefits of the Plan of the parent whose birthday falls earlier in the calendar year are determined before those of the Plan of the parent whose birthday falls later in that calendar year; but
 - b. If both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

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

3. **DEPENDENT CHILD/SEPARATED OR DIVORCED PARENTS.** If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - a. First, the Plan of the parent with custody of the child;
 - b. Then, the Plan of the spouse of the parent with custody of the child; and
 - c. Finally, the Plan of the parent not having custody of the child.

Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the dependent child shall be determined according to rule 2.

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 entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. **ACTIVE/INACTIVE EMPLOYEE.** The benefits of a Plan which covers You as an employee who is neither laid off nor retired or as Your Dependent are determined before those of a Plan which covers You as a former employee or as Your 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 is ignored.

5. **CONTINUATION COVERAGE.** The benefits of a Plan which covers You as an employee, member, or subscriber, or as a Dependent of such a person, are determined before those of a Plan which covers You as a person on state or federal continuation. 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 is ignored.
6. **LONGER/SHORTER LENGTH OF COVERAGE.** If none of the above rules determines the order of benefits, the benefits of the Plan which covered You, as a member or subscriber longer are determined before those of the Plan which covered You for the shorter time.

EFFECT ON THE BENEFITS OF THIS PLAN

This Section applies when, in accordance with the Order of Benefit Determination Rules, This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to below as "the other Plans."

The benefits of This Plan will be reduced when the Allowable Expenses in a Claim Determination Period are less than the sum of:

1. The benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and
2. The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made.

In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in

proportion. It is then charged against any applicable benefit limit of This Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. We have the right to decide which facts We need. We may get needed facts from, or give them to, any necessary organization or person. We need not tell or get the consent of any person to do this. Each person claiming benefits under This Plan must give Us any facts We need 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, We 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. We will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments We made is more than We should have paid under this COB provision, We may recover the excess from one or more of:

1. The persons We have paid or for whom We have paid;
2. Insurance companies; or
3. Other organizations.

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

10 TERMINATION OF COVERAGE

Generally, no benefits are available to You after the date Your coverage ends. Your coverage ends on the earliest of the following dates:

1. The date the Contract terminates.
2. The last day of the month in which You no longer meet the eligibility requirements.
3. The last day of the month in which the last premium contribution is made, either by You or on Your behalf.

CONTINUATION OF COVERAGE UNDER COBRA

If You, the Subscriber, terminate or are terminated from Your employment (for reasons other than gross misconduct) or Your hours are reduced, You can continue Your coverage up to 18 months. If the Social Security Administration determines that You were disabled when You lost Your job or within 60 days after, You and Your Dependents may be eligible for 29 months of continuation. If You have Family Coverage and Your Dependents lose coverage because 1) You die or are divorced, or 2) You become eligible for Medicare, Your Dependents may continue coverage up to 36 months. A child who is no longer an eligible Dependent may also continue coverage up to 36 months. Covered retirees and widows or widowers of retirees may have longer continuation rights if the Group files a Chapter 11 bankruptcy petition. You must tell the Group if You divorce or legally separate, or if Your child is ineligible within 60 days of the date it happens. The person losing coverage will be notified of the right to buy continued coverage. He or she will then have 60 days to elect the coverage and pay the required premium, and another 45 days to pay the premium covering the time period before the election.

Special COBRA rights apply to Subscribers who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. These Subscribers are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days (or less) and only during the 6 months immediately after their group health plan coverage ended.

If You, the Subscriber, qualify for assistance under the Trade Act of 1974, You should contact the Group for additional information. You must contact the Group promptly after qualifying for assistance under the Trade Act of 1974 or You will lose these special COBRA rights.

Premium will be no more than 102% of the Group rate (if Your coverage continues beyond 18 months because of a disability, premium in the 19th through 29th months may be 150% of the Group rate). Continued coverage ends earlier if the plan ends or if the person covered;

- fails to pay premium timely;
- becomes covered under another group health plan which contains no pre-existing condition limitations or exclusions;
- becomes covered under another group health plan which contains a pre-existing condition limitation or exclusion which You have satisfied pursuant to the federal Health Insurance Portability and Accountability Act of 1996, as first enacted or later amended; or
- becomes entitled to Medicare benefits.

11 GENERAL PROVISIONS

REIMBURSEMENT

If We pay benefits on behalf of You or Your Dependents in excess of the benefits required by this Contract, You must reimburse Us the excess benefits. The reimbursement is due and payable as soon as We notify You and demand reimbursement. We may also recover benefits paid from any person or provider to whom the payments were made. We may reduce benefits or an allowance for benefits as a set-off toward reimbursement. Even though We continue to provide or pay benefits, We may still enforce this provision. This provision is in addition to, not instead of, any other remedy We have at law or in equity.

PROOF OF LOSS

Either You or the Dentist may submit Your claim. In either case, We must receive proof of loss within 90 days of the date of service.

We will still process the claim if:

1. It was not reasonably possible for You to give Us proof of loss within 90 days; and
2. You give Us proof as soon as You are reasonably able, but not more than 15 months after You receive care.

Claims which We receive more than 15 months after You receive care will not be processed or paid.

PAYMENT OF CLAIMS AND GRIEVANCE PROCESS

Contract benefits are payable directly to You, the Subscriber. However, at Our option, We may choose to make payment directly to the provider of services. If You or Your Dependent sign a claim form indicating that the provider is to be paid directly, We accept that signature as authorization to exercise Our option. We may also pay the

provider directly if the provider has a written agreement with Us.

We will send You written notice regarding the claim within 30 days of receiving the claim, unless special circumstances require more time. This notice explains the reason(s) for payment or nonpayment of a claim. If a claim is denied because of incomplete information, the notice indicates what additional information is needed. You may contact Our Customer Service department for more details of Our decision.

If You still disagree with Our claim payment or denial, You may file a Grievance. The Grievance must:

1. Be in writing; and
2. Provide pertinent information such as identification number, patient's name, date and place of service, and reason for requesting the review.

It will be helpful if You identify Your letter as a Grievance. We will acknowledge Your Grievance within five (5) days of receiving it. We will examine all relevant facts including any material or records which you submit. You have the right to inspect all documents and records pertaining to his/her claim for benefits. You may appear before the Grievance Committee to present more information You wish the Committee to consider. We will notify You of the meeting time and place of the Committee meeting at least seven (7) days in advance. After review, We will provide a written decision, including reasons, within 30 days of receiving the Grievance. If special circumstances require a longer review period, We will notify You of the reason why, and when a decision may be expected. If We need the extra days, We will provide Our written decision within 60 days of receiving the Grievance.

In certain circumstances, you may request that We review your Grievance within seventy-two (72) hours. You may do this if the standard Grievance resolution process would include any of the following:

1. Serious jeopardy to your life or health or your ability to regain maximum function;
2. A situation where, in the opinion of a Dentist with knowledge of your medical condition, You would be subjected to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Grievance; or
3. A situation where, in the opinion of a Dentist with knowledge of your medical condition, that you must receive the treatment that is the subject of the Grievance right away.

You may file an expedited Grievance via a phone call to Us. You must provide the pertinent information listed above. We will resolve the expedited Grievance within seventy-two (72) hours of receiving it.

You can also contact the Office of the Commissioner of Insurance, a state agency that enforces Wisconsin's insurance laws, and file a complaint. You can contact the Office of the Commissioner of Insurance by writing to:

OFFICE OF THE COMMISSIONER OF INSURANCE
 Complaints Department
 P.O. Box 7873
 Madison, WI 53707 - 7873

or You can call 1-800-236-8517 outside of Madison or 266-0103 and request a complaint form.

ALLOWABLE CHARGES VERIFICATION

You may contact Our Customer Service area prior to having a procedure performed to determine if the provider's estimated charge is within our Maximum Allowed Amount. You must provide Us with the following information:

1. Date of service;
2. Place of service;
3. Valid 5 digit C.P.T. or A.D.A. code; and
4. Provider's estimated charge.

RELEASE OF INFORMATION

You must do all things reasonably necessary to help Us determine benefits payable. This includes authorizing the release of medical, or dental information, including names of all Dentists from whom You received treatment. We have no liability for any charge made by a provider for the copying or furnishing of the information.

TRANSFER OF BENEFITS

Only You, the Subscriber, and Your Dependents, as shown on Our records, are entitled to Contract benefits. These rights are forfeited if You or any Dependent:

1. Transfer those rights; or
2. Aid any person in fraudulently obtaining Contract benefits.

You and Your Dependents must reimburse Us for any benefits We have paid in this context.

DETERMINATION OF BENEFITS

1. If benefit levels change under this Contract, You are entitled to the level of benefits in effect on the date services or supplies were rendered.
2. You may request an advance determination as to whether a treatment, service, or supply is a Dental Service. Submit the request in writing to the Customer Service department of the regional service center responsible for servicing the Group. Where We give prior written approval, We pay benefits if, at the time the treatment, service, or supply is provided:
 - a. The Member's coverage is in force; and
 - b. Our approval has not expired.

3. Benefits under this plan will be paid only if the We decide in Our discretion that the applicant is entitled to them. The Group gives Us the discretionary authority to determine eligibility for coverage and benefits, and to construe the terms of the Contract. Furthermore, We have the right to determine the parameters used to identify claims that will be investigated. Our decisions shall not be overturned unless determined to be arbitrary and capricious.
4. We will consider alternative treatment plans proposed by You or on Your behalf. As part of this, We may extend benefits for services which are not usually covered Dental Services. The services must be Medically Necessary, cost-effective, and feasible. We do this on a case-by-case basis. We may stop the extra benefits at any time.

SUBROGATION

You agree that We are subrogated to all rights to damages, reimbursement, or payment which arise out of an illness or Injury, to the extent that We have paid, or are obligated to pay, benefits for the illness or Injury. You agree that those rights are assigned to Us. You also agree to cooperate with Us in Our recovery efforts, and not to compromise or hinder Our claim. We have the right to recover from anyone. However, We may not recover from You unless You have been made whole. Whether You have been made whole takes into account Your degree of fault. A judge will decide any disputes as to whether the person has been made whole.

LEGAL ACTION

You may not start legal action against Us until the earlier of:

1. 60 days after You file notice of claim and complete the Grievance process; or

2. The date We deny the claim and You complete the Grievance process.

You may not start legal action against Us later than 3 years from the time written proof of loss was required to be filed. You must file written proof of loss within 15 months of the date of service. This means any legal action must be started within 51 months of the first date of services on which the action is based.

REPRESENTATIONS

We deem any statement made by You, the Subscriber, to be a representation, not a warranty. We will not use Your statement against You unless the statement is in a written application signed by You. We will give You or Your beneficiary a copy of the application.

IMPORTANT NOTE

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



Underwritten by Blue Cross Blue Shield of Wisconsin

Notice of Privacy Practices



Information That's Important to You

Every year, we're required to send you specific information about your rights, your benefits and more. This can use up a lot of trees, so we've combined a couple of these required annual notices. Please take a few minutes to read about:

- State notice of privacy practices
- HIPAA notice of privacy practices
- Breast reconstruction surgery benefits

Want to save more trees? Go to anthem.com and sign up to receive these types of notices by e-mail.

State notice of privacy practices

As mentioned in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

Your personal information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter.

We may collect PI about you from other persons or entities, such as doctors, hospitals or other carriers. We may share PI with persons or entities outside of our company - without your OK in some cases. If we take part in an activity that would require us to give you a chance to opt out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity. You have the right to access and correct your PI. Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you. A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

HIPAA notice of privacy practices

This notice describes how health, vision and dental information about you may be used and disclosed, and how you can get access to this information with regard to your health benefits. Please review it carefully.

We keep the health and financial information of our current and former members private, as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan.

For health care operations: We use and share PHI for health care operations.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital.

Examples of ways we use your information for payment, treatment and health care operations:

- We keep information about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share explanation of benefits (EOB) with the subscriber of your plan for payment purposes.
- We may share PHI with your health care provider so that the provider may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.
- We may also use and share PHI directly or indirectly with health information exchanges for payment, health care operations and treatment. If you do not want your PHI to be shared for payment, health care operations, or treatment purposes in health information exchanges, please visit <https://www.anthem.com/health-insurance/about-us/privacy> for more information.

To you: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To others: In most cases, if we use or disclose your PHI outside of treatment, payment, operations or research activities, we must get your OK in writing first. We must receive your written OK before we can use your PHI for certain marketing activities. We must get your written OK before we sell your PHI. If we have them, we must get your OK before we disclose your provider's psychotherapy notes. Other uses and disclosures of your PHI not mentioned in this notice may also require your written OK. You always have the right to revoke any written OK you provide.

You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI for other types of activities including:

- Health oversight activities;
- Judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents);

- Organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety;
- Special government functions, for Workers' Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes; and
- As required by law.

If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. If your employer pays your premium or part of your premium, but does not pay your health insurance claims, your employer is not allowed to receive your PHI - unless your employer promises to protect your PHI and makes sure the PHI will be used for legal reasons only.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic information: We cannot use or disclose PHI that is an individual's genetic information for underwriting.

Race, Ethnicity, and Language. We may receive race, ethnicity, and language information about you and protect this information as described in this Notice. We may use this information for various health care operations which include identifying health care disparities, developing care management programs and educational materials, and providing interpretation services. We do not use race, ethnicity, and language information to perform underwriting, rate setting or benefit determinations, and we do not disclose this information to unauthorized persons.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI, including a request to receive a copy of your PHI through e-mail. It is important to note that there is some level of risk that your PHI could be read or accessed by a third party when it is sent by unencrypted e-mail. We will confirm that you want to receive PHI by unencrypted e-mail before sending it to you.
- Ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask him or her to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI. Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. Customer Service representatives can give you the address to send the request. They can also give you any forms we have that may help you with this process.

- **Right to a restriction for services you pay for out of your own pocket:** If you pay in full for any medical services out of your own pocket, you have the right to ask for a restriction. The restriction would prevent the use or disclosure of that PHI for treatment, payment or operations reasons. If you or your provider submits a claim to Anthem, Anthem does not have to agree to a restriction (see Your Rights section above). If a law requires the disclosure, Anthem does not have to agree to your restriction.

How we protect information

We are dedicated to protecting your PHI, and have set up a number of policies and practices to help make sure your PHI is kept secure.

We have to keep your PHI private. If we believe your PHI has been breached, we must let you know.

We keep your oral, written and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong out of areas where sensitive data is kept. Also, where required by law, our affiliates and nonaffiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law and outlined in this notice.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override, other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Contacting you

We, including our affiliates or vendors, may call or text any telephone numbers provided by you using an automated telephone dialing system and/or a prerecorded message. Without limitation, these calls may concern treatment options, other health-related benefits and services, enrollment, payment, or billing.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

Please call Customer Service at the phone number printed on your ID card. Representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Effective Date of this notice

The original effective date of this Notice was April 14, 2003. The most recent revision date is indicated in the footer of this Notice.

Breast reconstruction surgery benefits

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.

All applicable benefit provisions will apply, including existing deductibles, copayments and/or co-insurance. Contact your Plan administrator for more information.

For more information about the Women's Health and Cancer Rights Act, you can go to the federal Department of Labor website at: dol.gov/ebsa/publications/whcra.html.

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

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 مجاناً. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة.
(TTY/TDD: 711)

Armenian

Ղուրք 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 aḥóót'í t'áá ni nizaad k'ehjí níká a 'doowo!t'áá jík'e. Naaltsos bee atah nilinigií bee nécho 'dólzingo nanitinigií bécsh bee hane 'i bikáá' áájj' hodiilnih. Naaltsos bee atah nilinigií bee nécho 'dólzingo nanitinigií bécsh bee hane 'i bikáá' áájj' hodiilnih. (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>.

