

A Guide to Your Benefits

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

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Anthem Blue Dental PPO Plan 100

Annual Benefit Limit: \$1,500
Annual Deductible: \$0

Summary of Benefits

This summary provides you with the brief descriptions of your benefits and the benefit payment percentages. For more complete information, see your *Anthem Blue Dental PPO and Anthem Blue Dental PPO Plus* Benefit Booklet. For a covered dental service, this Plan will pay the applicable percentage (shown in the “Plan’s Percentage” column) of the Anthem Blue Cross and Blue Shield maximum allowance for that service (up to the annual benefit limit).

Annual Deductible	Annual Benefit Limit
In-Network \$0	\$1,500 per member
Out-of-Network \$50/\$150	

Benefit	Plan’s Percentage		Additional Information <i>Please refer to your benefit booklet for any age or frequency limitations for procedures.</i>
	Network Dentist	Non-Network Dentist	
Annual Deductible	\$0	\$50/\$150	
Diagnostic and preventive services <i>(No Deductible)</i>	100%	80%	Covered services include oral evaluations, x-rays, cleanings, and specified space maintainers.
General (adjunctive) services <i>(Deductible may apply)</i>	80%	60%	Covered services include emergency palliative treatment, consultations, general anesthesia, I.V. sedation, office visits for observation, and other selected general services.
Restorative services <i>(Deductible may apply)</i>	80%	60%	Covered services include amalgam and anterior composite restorations and pin retention.
Endodontic services <i>(Deductible may apply)</i>	80%	60%	Covered services include root canal therapy, apexification, therapeutic pulpotomy, and other selected endodontic services.
Oral surgery services <i>(Deductible may apply)</i>	80%	60%	Covered services include simple and surgical tooth extractions and other selected oral surgery services.
Periodontal services <i>(Deductible may apply)</i>	80%	60%	Covered services include gingivectomy, crown lengthening, osseous surgery, soft tissue grafts, and other selected periodontal services.
Prosthodontic services <i>(Deductible may apply)</i>	50%	40%	Covered services include crowns/onlays, removable or fixed partials or dentures, implants and other selected prosthodontic services.
Orthodontic services	50/40% up to \$1,000. Covered services include orthodontic treatment for children only. An Orthodontic Services Addendum will be attached to this Summary of Benefits outlining this benefit.		
Missing tooth coverage	Not covered		

Please see the back of this page for additional information.
Anthem Blue Cross and Blue Shield Dental Customer Service: 1-800-231-2583

Choice in Dentist Selection

You may choose your general dentist from anywhere in the United States or abroad. You may visit the specialist of your choice without any referrals from your general dentist and you may change dentists as often as you like without notifying Anthem Blue Cross and Blue Shield (Anthem). However, when you choose an Anthem PPO dentist, you will have less out-of-pocket costs through lower (or no) deductibles and increased benefit payment percentages.

When you select one of Anthem Blue Cross and Blue Shield's network dentists, our dentists will:

- File the claim form with Anthem for you. You are responsible for filling out the top portion of the claim form while at the dentist's office.
- Accept payment directly from Anthem. You are responsible for working out the payment of your portion of the charges with your dentist. Anthem will pay our portion directly to the dentist and send you an explanation of benefits.
- Not bill more than the amount their contract with Anthem allows. This means if the procedure is a covered benefit, Anthem will pay the percentage stated on this *Summary of Benefits* sheet, up to your Plan's annual benefit limit.

You choose the benefits and savings you want:

Your coverage is greatest when you visit an Anthem PPO dentist. Anthem's PPO dentists have agreed to charge within our maximum allowance. This ensures that you will not be charged more than your coinsurance percentage for covered services up to your Plan's annual benefit limit.

If you choose a non-PPO dentist, you still have coverage. However, your benefit percentage is reduced and you have a larger deductible. You will be responsible for: 1) paying any difference between Anthem's maximum allowance and the dentist's billed/charged amount; and 2) filing the claim with Anthem.

Assigning Benefits (Sending Payment Directly to a Nonparticipating Dentist)

If you authorize insurance payments directly to a nonparticipating dentist, Anthem will send the benefit payment directly to the dentist. If you do not authorize direct payment, Anthem will send the benefit payment to you and you will be responsible for providing payment to the dentist. **Anthem requires your original signature on the dental claim form. Anthem does not accept prestamped or preprinted signature authorizations from the dental office.**

Least Costly Procedure

Anthem covers the least expensive treatment for covered services as accepted by the American Dental Association (ADA). For example, Anthem covers amalgam fillings (silver-colored fillings) on posterior teeth. If you choose a composite resin filling (tooth-colored filling), you pay the difference.

Pretreatment Estimate

When your dentist prescribes services exceeding \$300, we recommend he/she submit a treatment plan to Anthem. Anthem will then supply you with a pretreatment estimate identifying Anthem's financial liability for the services submitted. A pretreatment estimate does not guarantee benefits will be allowed for the service in question. Anthem will honor all valid pretreatment estimates provided that the terms and conditions of the dental plan benefit booklet and the member's eligibility requirements are met.

When to Call Customer Service

Please call us with any questions or concerns you have about your BluePreferred Dental plan. Call us toll-free Monday through Friday, 8:00 A.M. to 5:00 P.M. Mountain Time, at:

1-800-231-2583

Our Commitment to You

We are committed to providing you and your family a quality dental plan and outstanding customer service. Thank you for your participation in our dental program; we look forward to providing you exceptional dental benefits.

This Summary of Benefits is subject to the provisions of the group's dental contract and cannot modify or affect the group's dental contract in any way, nor shall you accrue any rights because of any statement in, or omission from, this Summary.

Welcome

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

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

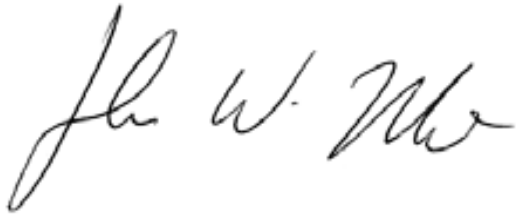
This Certificate should be read in its entirety. Since many of the provisions of this Certificate are interrelated, you should read the entire Certificate to get a full understanding of your coverage.

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

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

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

For questions about your dental coverage, please call Our customer service department at 800-627-0004.



John Martie
President and General Manager
Anthem Blue Cross and Blue Shield

TABLE OF CONTENTS

Glossary	3
Membership	7
How to Obtain Covered Services	14
Provider Choices	14
Non-Network Services	14
Choosing a Provider	14
Prior Carrier Authorizations	15
Not Liable for Provider Acts or Omissions	15
Identification Card	15
Covered Services	16
Diagnostic and Preventive Services	16
General (Adjunctive) Services	17
Restorative Services	17
Endodontic Services.....	17
Oral Surgery Services	18
Periodontal Services.....	18
Prosthodontic Services	19
Missing Tooth Benefit.....	20
Mouth Rehabilitation	20
Orthodontic Services	20
Cleft Palate and Cleft Lip Conditions	20
Pretreatment Estimates and Treatment Plans	20
Alternate Benefits.....	21
Exclusions	22
Claims Payment	25
General Provisions	27
Complaint, Appeal and Grievance Procedure	33

Glossary

This section defines terms that 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.

Alternate Benefits – Benefits for treatment or services that can be achieved through a different or less costly procedure or service with satisfactory results.

Annual Maximum – The maximum dollar amount Anthem will pay for Covered Services for each Member during a Benefit Year, according to the terms of this Certificate and the coverage outlined on the member's Summary of Benefits. The amounts applied to the Annual Maximum are based on the Maximum Allowable Amount for all Covered Services for which benefits were received. The annual benefit limit includes both Network and Non-Network services, but does not include the Member's Deductible or Coinsurance amounts. If your benefits cover 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 Summary of Benefits for any Annual Maximum or Lifetime Maximum amounts.

Anthem Blue Cross and Blue Shield is Rocky Mountain Hospital and Medical Service, Inc., a Colorado insurance company doing business as Anthem Blue Cross and Blue Shield. Also referred to as "Anthem", "we", "us" and "our".

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

Benefit Year – The Benefit Year is a calendar year: from January 1 through December 31 of the same year. The initial Benefit Year is from a member's effective date through December 31 of the same year. (A member's initial Benefit Year may be less than 12 months.) If your coverage ends earlier, the Benefit Year ends at the same time.

Certificate – This document, which explains the benefits, limitations, exclusions, terms, and conditions of this dental plan coverage and all endorsements, amendments, and riders attached hereto, now and in the future.

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.

Coinsurance — a provision under which you share costs with Anthem after the Deductible is met, according to a specific formula. The amount of Coinsurance you pay to a Provider is calculated after the determination of the Maximum Allowable Amount, but after Anthem subtracts any discount(s) that Anthem may have negotiated with the Provider.

Covered Services – Services and supplies or treatment as described in the Certificate. To be considered Covered Services, services must be:

- Within the scope of the license of the provider performing the service.
- Rendered while coverage under this Certificate is in force;
- Within the Maximum Allowable Amount;
- Authorized in advance by Anthem if this Certificate requires such preauthorization;
- Not specifically excluded or limited by the Certificate;
- Not Experimental or Investigational or otherwise excluded or limited by the Certificate;
- Medically Necessary or otherwise specifically included as a benefit under this Certificate.

Deductible – The dollar amount of Covered Services listed in the Summary of Benefits for which you are responsible before Anthem starts to pay for Covered Services each Benefit Year.

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

Effective Date – The date when a Subscriber's coverage begins under this Certificate. No benefits are provided for services and supplies received before your Effective Date or after your termination date.

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

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

Experimental/Investigational —

(a) Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation or treatment of a disease, injury, illness or other health condition which Anthem determines in its sole discretion to be experimental or investigational.

Anthem will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply to be experimental or investigational if it determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought.

The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA) or any other state or federal regulatory agency, and such final approval has not been granted.
- Has been determined by the FDA to be contraindicated for the specific use.
- Is provided as part of a clinical research protocol or clinical trial, or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function.
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as experimental/investigational, or otherwise indicate that the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation.

(b) Any service not deemed experimental or investigational based on the criteria in subsection (a) may still be deemed to be experimental or investigational by Anthem. In determining whether a service is experimental or investigational, Anthem will consider the information described in subsection (c) and assess all of the following:

- Whether the scientific evidence is conclusory concerning the effect of the service on health outcomes.
- Whether the evidence demonstrates that the service improves the net health outcomes of the total population for whom the service might be proposed as any established alternatives.
- Whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

(c) The information Anthem considers or evaluates to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is experimental or investigational under subsections (a) and (b) may include one or more items from the following list, which is not all-inclusive:

- Randomized, controlled, clinical trials published in authoritative, peer-reviewed United States medical or scientific journal.
- Evaluations of national medical associations, consensus panels and other technology evaluation bodies
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.
- Documents of an IRB or other similar body performing substantially the same function
- Consent documentation(s) used by the treating physicians, other medical professionals or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply
- The written protocol(s) used by the treating physicians, other medical professionals or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply
- Medical records
- The opinions of consulting providers and other experts in the field

(d) Anthem has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is Experimental or Investigational.

Family Coverage – Coverage for the Subscriber and eligible Dependents.

Group – The employer or other entity that has entered into a Group Contract with Anthem.

Group Contract (or Contract) – The contract between Anthem and the Group. It includes this Certificate, your Summary of Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

Identification Card – A card issued by Anthem that identifies the Membership by number, Effective Date of Coverage and may contain information about your coverage. It is important to carry this card with you.

Maximum Allowable Amount – The amount Anthem determines is the maximum amount payable for Covered Services, not to exceed charges actually billed. Anthem’s determination considers:

- Amounts charged by other Providers for the same or similar service.
- Any unusual medical circumstances requiring additional time, skill or experience.
- Other factors Anthem determines are relevant, including but not limited to, a resource based relative value scale.
- The amount accepted by a Network Provider as payment in full under the Network Provider’s participation agreement for this product.

After the Member’s share of Anthem’s Maximum Allowable Amount (deductible and Coinsurance) for a covered service has been calculated, Anthem pays any remaining amount up to the Maximum Allowable Amount (not to exceed the annual benefit limit).

For Network Providers, the Maximum Allowable Amount is equal to the amount that constitutes payment in full under the Network Provider’s participation agreement for this product. If a Network Provider accepts as full payment an amount less than the negotiated rate under the participation agreement, the lesser amount will be the Maximum Allowable Amount.

For a Non-Network Provider, even if the Provider has a participation agreement with Anthem for another product, the Maximum Allowable Amount is the lesser of the actual charge or our then effective Non-Network Benefit Schedule. It is your obligation to pay any Coinsurance, Deductibles and any amounts that exceed the Maximum Allowable Amount.

Medically Necessary — an intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that Anthem solely determines to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury.
- Obtained from a physician and/or licensed, certified or registered Provider.
- Provided in accordance with applicable medical and/or professional standards.
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes.
- The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained as an outpatient).
- Cost-effective compared to alternative interventions, including no intervention (“cost effective” does not mean lowest cost).
- Not Experimental/Investigational.
- Not primarily for the convenience of the Member, the Member’s family or the Provider.
- Not otherwise subject to an exclusion under this Certificate.

The fact that a Provider may prescribe, order, recommend or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary or a Covered Service. Anthem bases its decisions about medical necessity on medical policy developed by Anthem. Anthem may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of dental care services and technology.

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

Network Provider – A Provider who has entered into a contractual agreement for direct billing of covered services, and who agrees to accept Anthem’s benefit payment plus the Member’s share of Anthem’s Maximum Allowable Amount (Deductible and Coinsurance) as payment in full for such Covered Services for the Network associated with this Certificate.

Non-Network Provider – A Provider who has not entered into a contractual agreement with Anthem for the Network associated with this Certificate.

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

Pretreatment Estimate – A Pretreatment Estimate identifies Anthem’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
- Coinsurance
- Maximum benefit limitations

Such estimates are subject to the terms of the Member’s coverage, and may include an allowance for Alternate Benefits.

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

Recovery – Recovery is money the member, the member’s legal representative, or beneficiary receives, whether by settlement, verdict, judgment, order or by some other monetary award or determination, from another, from their insurer, or from any uninsured motorist, underinsured motorist, medical payments, no-fault, personal injury protection, or any other insurance coverage, as a result of injury or illness to the member. Regardless of how the member, the member’s legal representative, or beneficiary or any agreement may characterize the money received, it shall be subject to the **SUBROGATION AND RIGHT OF REIMBURSEMENT** provisions of this Certificate.

Subscriber – An employee of the Group who is eligible to receive benefits under the Group Contract.

Treatment Plan – A detailed description, submitted by the Provider, outlining the proposed services and fees including any appropriate radiographs and diagnostic information. A new Treatment Plan must be filed if the patient’s condition changes, or if the treatment is not completed within 120 days of the approval date.

Membership

Coverage provided under this Certificate is made available to you because of your employment with or Membership with your Employer Group.

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

Eligibility

Unless Anthem and the Group agree otherwise and notify you accordingly, the following eligibility rules apply:

Subscriber

To be eligible to enroll as a Subscriber, you must:

- Reside or work in the Service Area.
- Be an employee of the Group who is entitled to participate in the benefit plan arranged by the Group, who has satisfied any probationary or waiting period established by the Group, and meets the eligibility criteria stated in the Group Contract.
- Former employees of the Group may also be eligible for coverage, if specified in the Group Master Contract (e.g., retirees or COBRA eligible Members).

Anthem reserves the right to verify an employee's eligibility for coverage by requesting proof that a valid employer-employee relationship exists and that the employee otherwise meets the eligibility requirements as stated in the Group Contract and the employee's application.

Dependents

A Subscriber's Dependents may include the following:

- Legal Spouse.
- **Common-law Spouse.** The Subscriber must submit a Common-Law Marriage Affidavit for the common-law Spouse to be considered for enrollment. The Common-Law Marriage Affidavit may be obtained through the employer or by calling Our customer service department. All references to spouse in this Certificate include a Common-Law spouse.
- **Newborn child.** A newborn child born to the Subscriber or Subscriber's Spouse is covered under the Subscriber's coverage for the first 31 days after birth. If the mother of the newborn child is a Dependent child of the Subscriber, the newborn is **not** covered (see the **Grandchild** heading in this section).

During the first 31-day period after birth, coverage for a newborn child shall consist of Medically Necessary care for injury and sickness, including well child care and treatment of medically diagnosed Congenital Defects and Birth Abnormalities, without regard to the limitations and exclusions applicable to other conditions or procedures of this Certificate. All services provided during the first 31 days of coverage are subject to the Cost Sharing requirements and any benefit maximums applicable to other sicknesses, diseases and conditions otherwise covered.

To continue the newborn child's participation in the coverage beyond the 31-day period after the newborn child's birth, the Subscriber must complete and submit an Enrollment Application and Change Form to add the newborn child as a Dependent child to the Subscriber's policy. We must receive the Enrollment Application and Change Form within 31 days after the birth of the child to continue coverage for the 32nd day and thereafter.

- **Adopted child.** An unmarried child (who has not reached 18 years of age) adopted while the Subscriber or the Subscriber's Spouse is enrolled in coverage will be covered for 31 days after the date of placement for adoption. "Placement for adoption" means circumstances under which a Subscriber assumes or retains a legal obligation to partially or totally support a child in anticipation of the child's adoption. A placement terminates when the legal obligation for support terminates.

To continue the adopted child's participation in the coverage beyond the 31-day period after the adopted child's placement, the Subscriber must complete and submit an Enrollment Application and Change Form to add the adopted child as a Dependent child to the Subscriber's policy. We must receive the Enrollment Application and Change Form within 31 days after the placement of the child for adoption to continue coverage for the 32nd day and thereafter.

- **Dependent child.** An unmarried child (including a stepchild or a disabled child) under 19 years of age may be covered under the terms of this Certificate. At the end of the birth month in which the child turns age 19 the dependent child is removed from coverage. The dependent child may qualify as an overage dependent child as explained below. If the Subscriber or the Subscriber's Spouse is subject to a qualified medical child support order for a Dependent child of the Subscriber or the Subscriber's Spouse, the Dependent child is eligible for coverage, whether the child lives with the Subscriber or the Subscriber's Spouse.
- **Overage Dependent child.** An unmarried child age 19 through age 24 who is financially dependent on the parent may be covered under the terms of this certificate. At the end of the birth month of the limiting age, the child is automatically removed from the coverage as a dependent. Anthem may require substantiating documentation of financial dependency, e.g., a current school class schedule, and proof of registration or proof of tuition payment, for an overage dependent to continue coverage. A completed Overage Dependent Enrollment Request Form and substantiating documentation must be submitted annually for coverage of the overage dependent child to continue. A member may obtain an Overage Dependent Enrollment Request Form from the employer or Anthem's customer service department. A dependent child who is no longer eligible for coverage may be eligible for continuation coverage. Information can be found under the heading *Continuation of Coverage* in this section.
- **Disabled Dependent child.** An unmarried child who is 19 years of age or older, medically certified as disabled, and Dependent on the parent may be covered under the terms of this Certificate. We must receive notice of the disability for the disabled Dependent coverage to continue after the Dependent child turns age 19. The Subscriber and the disabled Dependent's Physician must complete and submit a Mentally or Physically Disabled Dependent Form to Us. You may call Our customer service department or visit Our website to obtain a Mentally or Physically Disabled Dependent Form.
- **Grandchild.** A grandchild of a Subscriber or a Subscriber's Spouse is not eligible for coverage unless the Subscriber or the Subscriber's Spouse is the grandchild's court-appointed permanent guardian or has adopted the grandchild. The Subscriber must submit an Enrollment Application and Change Form and evidence of court appointment as permanent guardian or documents evidencing a legal adoption.

Enrollment Process

For eligible Subscribers and their eligible Dependents to obtain coverage, the Subscriber must follow Our enrollment process, which details who is eligible and what forms are required for enrollment. Coverage under this Certificate begins as of the Effective Date as indicated in Our files. No services received before that date are covered.

Note: Submission of an Enrollment Application and Change Form does not guarantee your enrollment.

Enrollment Forms

The Subscriber must submit an Enrollment Application and Change Form to add any Dependents as Members. Additional forms may be required for special Dependent status. Subscribers may obtain an Enrollment Application and Change Form or any additional forms from their employer, Our customer service department or Our website.

Initial Enrollment

Eligible employees may apply for coverage for themselves and their eligible Dependents by submitting an Enrollment Application and Change Form. We must receive the Enrollment Application and Change Form within 31 days after the date of hire or within 31 days of the expiration of the waiting period, as defined in the employer's new hire policy. The Effective Date of coverage will be determined in accordance with any established waiting period as defined in the Employer Master Contract. The employer will inform the employee of the length of the waiting period.

Open Enrollment

Any eligible employee who has satisfied the waiting period as defined by the employer may enroll during the employer's annual Open Enrollment period, which is generally a 31-day period before the employer's Anniversary Date. The employer's benefit coordinator will provide the Open Enrollment period date and the Anniversary Date to the eligible employee.

Newly Eligible Dependent Enrollment

A current Subscriber of this coverage may add a Dependent who becomes newly eligible due to a qualifying event. Qualifying events include marriage, birth, placement for adoption or issuance of a court order. We must receive an Enrollment Application and Change Form for the addition of the Dependent within 31 days after the date of the qualifying event. Proof of the qualifying event, e.g., a copy of the marriage certificate or court order, must be attached to the completed Enrollment Application and Change Form. Coverage will be effective on the date of the qualifying event.

When the Subscriber or the Subscriber's Spouse is required by a court or administrative order to provide coverage for an eligible dependent for child support, the eligible Dependent must be enrolled within 31 days of the issuance of such order. We must receive a copy of the court or administrative order with the Enrollment Application and Change Form. If the Subscriber does not enroll the eligible Dependent within 31 days of the issuance of the order, the Subscriber must wait until the next Open Enrollment to enroll the Dependent.

Special Enrollment for Eligible Employees and Eligible Dependents

Special enrollment is available for eligible employees and their eligible Dependents who currently are not enrolled in the employer health coverage with Us. Special enrollment is allowed when a family status change occurs or when the involuntary loss of coverage occurs.

Family Status Change - Qualifying events for special enrollment due to a family status change include marriage, divorce, birth, placement for adoption or the issuance of a qualified medical child support order. Coverage with Us will be effective on the date of the qualifying event. When the qualifying event is a birth, and the mother is not previously enrolled, any charges related to labor and delivery due to the birth are not covered. We must receive the completed Enrollment Application and Change Form within 31 days after the date of the qualifying event. Proof of the qualifying event, e.g., a copy of the marriage certificate or court order, must be attached to the completed Enrollment Application and Change Form.

Involuntary Loss of Coverage – For the eligible employee and/or eligible Dependent to qualify for special enrollment due to involuntary loss of the other group health insurance coverage, the loss of coverage must be due to termination of employment, reduction in the number of hours of employment, involuntary termination of Creditable Coverage, death of a Spouse, legal separation or divorce, or termination of employer contributions toward the coverage. If the employee is approved for special enrollment, the coverage with Us will be effective on the day following the loss of other coverage. If COBRA or state continuation coverage is available, enrollment may only be requested after exhausting the COBRA or state continuation coverage.

Late Entrants

To qualify as a late entrant (including voluntary loss of coverage) at any time, you must complete and submit an Enrollment Application and Change Form and Health Statement. If approved, coverage will be effective on the first of the month following Our receipt and approval of the Subscriber's Enrollment Application and Change Form and Health Statement.

If you had no prior coverage within 90 days of enrollment you may apply for coverage as a late entrant if you did not request enrollment under one of the following circumstances:

- During the initial enrollment period.
- During the Open Enrollment period.
- As a newly eligible person.
- After a qualifying event for special enrollment occurred.

If you enroll as a late entrant, your eligible dependents seeking coverage at the same time will also be late entrants.

Military Service

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their dependents covered under the Plan before leaving military service:

- The maximum period of coverage of a person under such an election shall be the lesser of;
 - The 24 month period beginning on the date on which the person's absence begins; or
 - The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or waiting period may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

How to Change Coverage

If a group provides you with multiple dental care options, eligible employees may switch coverage for themselves and/or their eligible Dependents to another coverage offered by the group during Open Enrollment.

Termination

Active Policy Termination

Your coverage ends on the first occurrence of one of the following events:

- On the date the Employer Master Contract between the employer and Us is terminated.
- Upon the Subscriber's death.
- When the required Premium has not been paid.
- When you or your employer commits fraud or intentional misrepresentation of material fact.
- When you are no longer eligible for coverage under the terms of the Employer Master Contract.
- When you are deemed a "working aged," as defined by federal law, and Medicare becomes your primary coverage unless you are in a group with fewer than 20 employees.
- When the Subscriber's employer gives Us written notice that the Subscriber is no longer eligible for coverage. Coverage will be terminated on the date of notification or at the end of the month of the qualifying event. We reserve the right to recoup any benefit payments made for dates of service after the termination date.
- When We receive a 31-day advance written notification to cancel coverage for any Member, coverage will end at the end of the month following the 31-day advance written notification period or at the end of the month of the qualifying event. We will credit membership Premium paid in advance on behalf of canceled Members unless We do not receive the cancellation request at least 31 days before the Effective Date of the cancellation.
- When We cease operations.

Dependent Coverage Termination

To remove a Dependent from coverage, the Subscriber must complete an Enrollment Application and Change Form 31 days before the Effective Date of the change. If we receive the change notification after the requested Effective Date, the change will be effective on the date We are notified of the change. We reserve the right to recoup any benefit payments made after the termination date.

We will credit membership Premium paid in advance on behalf of the terminated Dependent unless We do not receive the Enrollment Application and Change Form within 31 days before the Effective Date of the change or if We have paid any claims on behalf of the terminated Dependent in the period for which the credit would otherwise be owed to the employer.

Coverage for a Dependent ends on the last day of the month immediately preceding the next monthly Premium due date following receipt of the request or on the first occurrence of one of the following events:

- At the end of the month when the Subscriber notifies Us in writing to cancel coverage for a Dependent.

- When the Dependent child marries or no longer qualifies as a Dependent by definition. Such a Dependent has the right to elect COBRA or state continuation coverage.
- On the date of a final divorce decree or legal separation for a Dependent Spouse. Such a Dependent has the right to elect COBRA or state continuation coverage.
- At the end of the month when legal custody of a child placed for adoption is terminated.

What We Will Pay for After Termination

Except as provided below, We will not pay for any services provided after your coverage ends even if we preauthorized the service, unless the Provider verified the Member's eligibility within two business days before each service received. Benefits cease on the date your coverage ends as described above. You may be responsible for benefit payments made by Us on your behalf for services provided after your coverage has terminated.

When your coverage is terminated for any reason other than for nonpayment of Premium, fraud or abuse, We shall provide for your continued care if you are being treated at an inpatient facility, until you are discharged or transferred to another level of care, subject to the terms of this Certificate. The discharge date is considered the first date on which you are discharged from the facility or transferred to another level of care. When coverage has been terminated and you receive additional facility care after the discharge date, We will not cover additional services received.

We do **not** cover services received after your date of termination even if:

- We preauthorized the services.
- The services were made necessary by an accident, illness or other event that occurred while coverage was in effect.

Continuation of Coverage

Family and Medical Leave Act

When an employee takes time off from work pursuant to the Family and Medical Leave Act, dental insurance coverage remains in force but the employee may be required to continue paying the employee's share of the Premium. You may contact your benefit coordinator with your employer for details.

State Continuation Eligibility and Notification

State Continuation Coverage Eligibility - Employers with fewer than 20 employees who provide dental care coverage for their employees are subject to state law regarding continuation of coverage. The state continuation coverage period will not exceed 18 months for the employee and/or any Dependents. State continuation coverage for employees and their Dependents will commence on the date of the earliest of the following qualifying events:

- The employee's termination of employment or reduction in working hours resulting in loss of coverage. To qualify, you must have been covered by the employer's group dental coverage for at least (6) six consecutive months.
- The employee's death.
- Divorce or legal separation of the employee and Spouse.
- Loss of active Dependent status under requirements of the coverage.

State Continuation Coverage Notification - Unless termination or reduction in working hours is the qualifying event, a Subscriber, Spouse or Dependent child must notify the employer of their election to continue coverage within 30 days after becoming eligible. The employer is responsible for notifying the Subscriber, Spouse and/or Dependent child of how to elect continuation coverage. Once the employer has provided notice to the Subscriber, Spouse and/or Dependent child, We must receive timely notice from the employer that you are electing state continuation coverage. We must also receive timely payment of appropriate Premium charges from the employer when paid by the Subscriber for you to be eligible for state continuation coverage.

Under state continuation coverage, We must receive notice from the employer and your first Premium payment no later than 30 days after the qualifying event (except that if the employer fails to give timely notice to the Subscriber of the Subscriber's continuation rights, this deadline may be extended to 60 days after the qualifying event). For more details, you may contact your employer.

COBRA Eligibility and Notification

COBRA Eligibility - For employers with 20 or more employees, Subscribers and their Dependents who lose eligibility with a group may be eligible for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). You should contact the employer for additional information. COBRA coverage is available for 18, 29 or 36 months, depending on the qualifying event(s), and only if the application and Premium payment requirements of the federal law are met.

COBRA coverage is available to employees and their Dependents for 18 months from the date of the following qualifying events:

- When an employee loses coverage due to a reduction in working hours, including layoffs and strikes.
- When an employee loses coverage due to the voluntary or involuntary termination of employment, including retirement and excluding gross misconduct.

COBRA coverage is available for employees and their Dependents for 29 months from the original qualifying event as described above in the following situation:

- When the Social Security Administration has determined that an employee or Dependent was disabled when coverage was terminated or within 60 days after the coverage was terminated, due to one of the qualifying events above, and the employee or Dependent is still disabled when the 18-month continuation period expires.

COBRA coverage is available for the individuals below for 36 months from the date of the following qualifying events:

- The surviving Spouse and surviving children of a covered employee, when the covered employee dies.
- The covered employee, if the employee became eligible for Medicare benefits before COBRA election.
- Spouses and Dependent children of a covered employee, when the employee and the Spouse separate or divorce.
- Dependent children of the covered employee, when the Dependent children lose eligibility as Dependents.

COBRA coverage is available to children born or placed for adoption during the period of COBRA coverage for the remainder of either the 18-month or 36-month COBRA continuation period. The qualifying event that triggered the COBRA coverage will determine the length of the continuation period for the newborn or adoptee.

COBRA Notification - Unless termination or reduction in working hours is the qualifying event, a Subscriber, Spouse or Dependent child must notify the employer of eligibility for COBRA coverage within 60 days after becoming eligible. Once the employer has provided notice to the Subscriber, Spouse and/or Dependent child or the right to elect COBRA, We must receive timely notice from the employer that you are electing COBRA coverage. We must also receive timely payment of appropriate fees or Premium charges for you to be eligible for COBRA.

The COBRA-eligible person has 60 days from the receipt of the employer notification or from the date the prior coverage would otherwise end, whichever is later, to elect COBRA coverage and to inform the employer of the election. To apply for COBRA coverage, the eligible person must complete a COBRA or State Continuation of Coverage Application. The employer must complete the employer section, sign the application and submit it to Us. After electing COBRA coverage, the Subscriber must pay the first fees or Premium due within 45 days. For more details, the Subscriber may contact the employer.

Termination of State Continuation Coverage or COBRA

Your continuation coverage terminates when the continuation period is exhausted. The duration of continuation coverage is detailed under the “State Continuation Eligibility” and “COBRA Eligibility” headings in this action.

Continuation coverage may terminate before the continuation period expires if:

- The Employer Master Contract between the employer and Us is terminated. If the employer selects a replacement group coverage, continuation coverage will continue under the new coverage.
- You fail to pay Premium in a timely manner.
- Under state continuation coverage, you are eligible for another group dental insurance policy unless the other coverage excludes a condition covered by the continuation coverage; in that case, the state continuation coverage continues until exhausted or the other coverage covers the excluded condition.
- Under COBRA coverage, you are covered by another group dental insurance policy unless the other coverage excludes a condition covered by the COBRA coverage; in that case, the COBRA coverage continues until exhausted or the other coverage covers the excluded condition.

- You become covered by Medicare.
- Your COBRA coverage was extended to 29 months and you are determined under the Social Security Act to no longer be disabled.
- You submit written notice of voluntary cancellation of coverage.

Conversion

Conversion coverage is not available under this certificate.

How to Obtain Covered Services

Provider Choices

Network Providers are the key to providing and coordinating your dental care services. Benefits are provided when you obtain Covered Services from Providers; however, the broadest benefits are provided for services obtained from Network Providers.

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. Anthem has final authority to determine whether the service is covered.

Anthem may inform you that the services you received are not covered by the contract. This decision is made upon review of your condition and treatment. You may appeal this decision. See Complaint and Appeal Procedures in the General Provisions section of your Certificate.

Network Providers - include dentists and other professional Providers who contract with Anthem 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 Anthem and not from you except for approved Coinsurance 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 Certificate.
- 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. Authorization must be obtained from Anthem prior to receiving services.

Non-Network Services

Services that are not obtained from a Network Provider or not an Authorized Service will be considered a Non-Network Service.

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 Coinsurance.
- Non-Covered Services
- Filing claims
- Possible higher cost sharing amounts

If a Non-Network Provider meets Anthem'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 Certificate.

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 Anthem for this product, contact a customer service representative.

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

Prior Carrier Authorizations

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

Relationship of Parties (Anthem - Network Providers)

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

Anthem 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.

Not Liable for Provider Acts or Omissions

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

Identification Card

When you receive care from a 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 this Certificate. To be entitled to such services or benefits you must be a Member on whose behalf all applicable Premiums under this Certificate have been paid. If you receive services or other benefits to which you are not then entitled under the provisions of this Certificate you will be responsible for the actual cost of such services or benefits.

Covered Services

This section describes the types of Covered Services available under your dental care benefits when provided and billed by Providers. A more detailed listing is provided in the Summary of Benefits. All Covered Services are subject to the exclusions listed in the Exclusions section of this Certificate and the Summary of Benefits. Covered Services must be Medically Necessary and not Experimental/Investigational. The amount payable for Covered Services varies depending on whether you receive your care from a Network Provider or a Non-Network Provider.

To receive maximum benefits for Covered Services, you must follow the terms of this Certificate, including, if applicable, use of Network Providers and obtaining any required prior authorization. Benefits for Covered Services are based on the Maximum Allowable Amount for such service. If you have an out of network benefit and use 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 applicable Deductible and Coinsurance. If you do not have an out of network benefit, your entire claim will be denied.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Certificate. Anthem's payment for Covered Services will be limited by any applicable Deductible or annual or lifetime payment limit in the Certificate, including the Summary of Benefits. The fact that a Provider may prescribe, order, recommend or approve a service does not make the service Medically Necessary or a Covered Service and does not guarantee payment. Anthem bases its decisions about referrals, preauthorization, medical necessity, experimental services and new technology on medical policy developed by Anthem. Anthem may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

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 Year 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 Year.
- **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 Year. 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 Anthem for diagnostic evaluation. Anthem 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 Year, 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 Year.
- **Sealants**, but only to the unrestored occlusal surface of permanent, posterior (molar) teeth, limited to once per Benefit Year 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 Year (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 Year (not covered when associated with other services or procedures).

Restorative Services

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

The following are covered restorative services under this Certificate:

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

Endodontic Services

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

Root Canal Therapy

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

Other Endodontic Services:

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

- **Apexification/recalcification**
- **Apicoectomy/periradicular** services (includes removal of granulation tissue at the apex of the tooth)
- **Retrograde filling**
- **Root amputation/hemisection**
- **Therapeutic pulpotomy** (excluding final restoration), limited to deciduous teeth only.

Oral Surgery Services

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

- **Simple tooth extractions**
- **Surgical tooth extractions**
- **Alveoloplasty**
- **Vestibuloplasty**
- **Surgical Biopsy**
- **Excision of soft tissue lesions**
- **Excision of intra-osseous lesions**
- **Excision of bone tissue**
- **Frenulectomy**
- **Excision of hyperplastic tissue**
- **Surgical incision and drainage**
- A biopsy report must be submitted with claims for the removal of tumors, cysts, or neoplasms.

Periodontal Services

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

Periodontal Surgical Services

Coverage for periodontal surgical services includes routine postoperative care, limited to one surgical procedure per quadrant per Member in any three years. Covered periodontal surgical services are:

- **Gingivectomy or gingivoplasty**, except when performed in conjunction with a crown build-up, post and core, or with a crown (the gingivectomy or gingivoplasty is considered part of that procedure and there will be no additional benefit).
- **Gingival flap procedure** (includes root planing)
- **Crown lengthening**, limited to once per tooth per lifetime.
- **Osseous surgery**, including flap entry with closure, limited to one quadrant of osseous surgery per Member in any three years. (Surgical site is limited to the number of teeth with periodontal pockets of at least 5mm)
- **Osseous grafts** (not in conjunction with extraction sites, ridge augmentation or in preparation for the placement of implants)
- **Soft tissue grafts** (includes donor site) (per site which is defined as a single graft covering two adjacent teeth)
- **Distal or proximal wedge procedure**, except when performed in conjunction with surgical procedures in the same anatomical area. (only when a periodontal pocket of 5mm or more exists)

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 Year.
- **Periodontal maintenance procedures** only when following active periodontal therapy, limited to two cleanings per Benefit Year, 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 Years.

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 Certificate or under any prior dental coverage, and even if the original crown was stainless steel or “temporary”). Available only if three or more surfaces of the tooth are being restored or a cusp is missing or the tooth has a completed root canal.

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 Year 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, 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 Year.
- **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 Year for chairside relining and once in three years for laboratory rebasing or relining.

Prosthodontics, Fixed

Each abutment and each pontic constitute a unit in a bridge. Covered Services are:

- **Fixed bridges**, but only when a less costly procedure is inappropriate as determined by Anthem, and only if the teeth being replaced were functional and extracted after the Member’s Effective Date. Anthem’s dental consultant may request a complete Treatment Plan in determining benefits when replacing multiple teeth in the same arch.

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

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

An alternate benefit for a removable partial denture is the maximum benefit available if more than 6 units of fixed bridgework is needed to replace all missing teeth in an arch, or if all molars are missing on one or both sides of an arch.

- **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.

Missing Tooth Benefit

Removable prosthodontics (partials or dentures) or fixed prosthodontics (bridges) for the replacement of teeth (or tooth) lost prior to the Member's Effective Date under this Certificate are **not** covered.

Mouth Rehabilitation

If you and your Dentist select a course of mouth rehabilitation, Anthem's obligation under this Certificate will be to cover only those services necessary to eliminate oral disease and replace covered missing teeth. The balance of the treatment, including costs of treatment and materials to increase vertical dimension or restore the occlusion, will remain the responsibility of the Member.

Orthodontic Services

This is an optional benefit. See your Summary of Benefits to determine if purchased by your Employer.

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 Summary of Benefits. Orthodontic services are not subject to the annual benefit limit. **A Treatment Plan is required for all orthodontic services. Refer to the Summary of Benefits for Orthodontic Age Limitations.**

For each eligible Member, after the Deductible (if any) is met, Anthem pays the applicable percentage shown in the Summary of Benefits of the Maximum Allowable Amount for the following orthodontic services:

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

Cleft Palate and Cleft Lip Conditions

Note: The following is a Covered Service only if the member is **not** enrolled in a medical coverage (with us or any other health insurance carrier) in addition to this dental coverage.

Benefits are allowed for Inpatient care and Outpatient care, including orofacial Surgery, surgical management and follow-up care by plastic surgeons and oral surgeons, orthodontics, prosthetic treatment such as obturators, speech appliances, and prosthodontic and surgical reconstruction for the treatment of Cleft Palate and/or Cleft Lip.

Pretreatment Estimates and Treatment Plans

A Treatment Plan from your Provider is recommended. A Pretreatment Estimate is available from Anthem for services exceeding \$300. If the Provider is a Network Provider, and requests a pretreatment estimate, then the Provider is responsible for obtaining the Pretreatment Estimate. If the Provider is a Non-Network Provider, the Member is responsible for making sure the Provider submits a written Treatment Plan, with the required documentation for the services, to Anthem if requested. Requests should be submitted on a standard claim form. Telephone requests cannot be accepted, and verbal authorizations are not honored.

Anthem 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. Anthems' Pretreatment Estimates are valid for 120 days, provided all other eligibility and requirements are met. If the approved procedure is not completed within the approved time period, or if the patient's condition changes, the Subscriber is responsible for asking the Provider to submit another request and Treatment Plan, along with the required, current documentation. A new Pretreatment Estimate must then be issued by Anthem.

Depending on the Treatment Plan, radiographs, and diagnostic information may be reviewed by actively practicing Dentists/Providers (when appropriate) who provide consultation services for Anthem. Anthem, with the consultant Dentist(s)/Provider(s), will determine the benefits available according to the terms and provisions of this Certificate.

Regardless of approval of a Treatment Plan, coverage under this Certificate must be maintained without interruption through the date that services are performed in order for benefits to be provided. If services are provided without the Pretreatment Estimate, benefits will be provided only for those services that would have been covered if covered by Anthem. Mail the Pretreatment Estimate request and Treatment Plan forms to the address listed on your Identification Card.

Alternate Benefits

Whenever a Provider performs or provides a treatment or service for which a satisfactory result could have been achieved through a different or less costly procedure or service, Anthem reserves the right to determine alternate benefits based upon the less costly procedure. When Anthem provides alternate benefits for a service, the Member is responsible for the balance of charges made by the Provider. If the Provider is a Network Provider, the Member will be responsible for the difference between the less costly procedure and the Anthem's Maximum Allowable Amount for the service or supply actually provided, plus any applicable Deductible and Coinsurance.

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. Anthem is the final authority for determining if services or supplies are covered. In addition to these exclusions, limitations also apply to Covered Services, see **your Summary of Benefits for those limitations**.

Anthem does not provide benefits for services or supplies:

- Which are not specifically listed in the Summary of Benefits or Certificate.
- Received from an individual or entity that is not a Provider, as defined in this Certificate.
- Which are Experimental/Investigational or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigational service or supply, as determined by Anthem.
- For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation. The payment of benefits under this Certificate will be coordinated with such governmental units to the extent required under existing state or Federal laws.
- For illness or injury that occurs as a result of any act of war, declared or undeclared.
- 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.
- For court ordered care, unless authorized by Anthem or otherwise covered by the Certificate.
- For which you have no legal obligation to pay in the absence of this or like coverage.
- Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
- Received from a relative, a person who lives in your home or who is related to you by blood, marriage or adoption..
- For completion of claim forms or charges for medical/dental records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For charges in excess of the Maximum Allowable Amount.
- Services received before your Effective Date or services received after your coverage ends. For individual procedures in a prescribed treatment plan, no benefits will be provided for treatment BEGUN before your Effective Date and/or COMPLETED after your coverage ends.
- Primarily for educational, vocational, or training purposes, except as otherwise specified herein.
- 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.
- For analgesics (includes nitrous oxide).
- For athletic mouth guards.
- For bacteriological studies for determination of pathologic agents.
- For behavior management.
- For bleaching of discolored teeth.
- For canal preparation and fitting of prefabricated dowel and post.
- For caries susceptibility tests.
- For chemical treatments.
- For cosmetic services for beautification or aesthetic services to improve an individual's appearance by alteration of a physical characteristic, for psychiatric or psychological reasons, or to change family characteristics or conditions due to aging or incisal wear; for cosmetic replacement of serviceable amalgam restorations with silicate, plastic, or composite materials.

- For crown buildups on the same tooth as an amalgam or composite restoration that was done within the same Benefit Period.
- For restorations to restore occlusion, vertical dimension or incisal edges due to bruxism, attrition or harmful habits.
- For desensitizing medicaments and/or their application.
- For diagnostic photographs, casts, or models.
- For dietary instructions.
- For discing.
- Related to temporomandibular joint (TMJ) dysfunction, therapy or surgery, regardless of the reason(s) such services are necessary.
- For enamel microabrasion.
- For fixed bridge when done in conjunction with a removable Appliance in the same arch.
- For grafts to improve aesthetics.
- For grafts to prepare for or that are associated with implants.
- For gold foil restorations.
- For guided tissue regeneration.
- For histopathological examinations.
- For house/hospital calls.
- For implants and services or supplies, such as bridges, grafts, or dentures, that are provided in conjunction with implants.
- For inlays and recementing of inlays.
- For local anesthetic when billed separately.
- For localized delivery of chemotherapeutic agents.
- For occlusal analysis.
- For oral hygiene instructions.
- For OSHA fees and/or infection control fees when billed separately.
- 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
- For polishing of restorations.
- For post removal.
- For precision attachments for partials and/or dentures.
- For prefabricated resin crown or stainless steel crown with resin window.
- For prescription drugs.
- For pulp capping (direct or indirect).
- For pulp vitality tests.
- For pulpotomy on permanent teeth.
- For rebonding of a Maryland bridge.
- For recontouring.
- For removable unilateral partial denture.
- For replacement of a nonfunctional or nonrestorable tooth, e.g., a bridge to replace an extracted tooth root. Radiographic verification of a sound tooth at the time of initial membership eligibility may be required.
- 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 Certificate or under any prior dental coverage).
- For replacement of restorations due to mercury or other possible allergies.
- For replacement of serviceable prosthodontics (services needed to make an Appliance serviceable will be provided in accordance with this Certificate).
- For resin crowns/onlays whether for single restorations, bridge retainers, or pontics.

- For restorations on the same tooth as a previously placed sealant if fewer than two years have elapsed since the time sealants were placed.
- For restoration overhang removal.
- For root canal therapy on deciduous teeth.
- For sealants on restored teeth (occlusal surface).
- For second professional opinions.
- For sedative fillings.
- For silicate restorations.
- For stress breakers.
- For temporary/interim prosthodontia or appliances (temporary crowns, bridges, partials, dentures, etc.).
- For therapeutic injections.
- For tissue conditioning procedures.
- For tobacco-use counseling.
- For upgrading of serviceable dentistry.
- For two similar services performed at the same time where one service is an integral part of a more extensive procedure.
- For prosthetic devices to replace teeth missing (congenitally or otherwise) lost or extracted before the Member's Effective Date.
- For orthodontic services or supplies unless purchased as an optional benefit.
- For mucogingival surgery.
- For occlusal adjustments (complete or limited) except as specified otherwise in the Certificate.
- For provisional splinting.
- For services and supplies that do not meet Anthem's dental or benefit policy guidelines.
- For services or supplies not specifically listed in the Summary of Benefits or Certificate.

Claims Payment

How to Obtain Benefits

When a Network Provider renders your care you are not required to file a claim, because Anthem is authorized to make payments to Network Providers. Therefore, provisions below regarding “Claim Forms” and “Notice of Claim” do not apply, unless the Provider did not file the claim.

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.

How Benefits Are Paid

Anthem shares the cost of your dental expenses with you up to the amount of the Maximum Allowable Amount. For services subject to a Deductible, you pay a portion of the bill before Anthem begins to pay its share of the balance. Some services are subject to a Coinsurance, others may be subject to both a Deductible and Coinsurance.

Network Providers will seek compensation from Anthem for Covered Services. When using a Network Provider you are only responsible for Coinsurance, Deductibles, non-covered charges, and amounts over the Annual or Lifetime Maximums. Network Providers have agreed to accept the Maximum Allowable Charge as payment in full for Covered Services. If you receive Covered Services from a Non-Network Provider, you are responsible for the difference between the actual charge billed and the Maximum Allowable Amount plus any Deductible, Coinsurance, non-covered charges, and amounts over the Annual or Lifetime Maximums. Coinsurance is your share of the cost for particular dental services, and is generally due at the time you receive the dental service. For Covered Services subject to Coinsurance, you pay a portion of the bill and Anthem pays its share of the balance. Refer to the Summary of Benefits to see what Coinsurance is required for each Covered Service.

The amount you pay may differ by the type of service you receive or by Provider. Refer to the Summary of Benefits to see what amount you are required to pay for each service. Claims for Covered Services need not be sent to Anthem in the same order that expenses were incurred.

Anthem will deny that portion of any charge that exceeds the Maximum Allowable Amount.

Payment of Benefits

All benefits in this Certificate will be paid directly to Network Providers, whether you have authorized assignment of benefits or not. Anthem may require a copy of the assignment of benefits for our records. We will pay Non-Network Providers directly when you assign benefits in writing no later than the time of filing proof of loss (claim). These payments fulfill our obligation to you for those services.

Assignment

This Certificate is not assignable by the Group without the written consent of Anthem. The coverage and any benefits under this Certificate are not assignable by any Member without the written consent of Anthem, except as described in this Certificate.

Notice of Claim

Anthem is not liable under the Certificate, unless Anthem 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.

Note: You have the right to obtain an itemized copy of your billed charges from the Provider who 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 Anthem. If you do not receive the forms, written notice of services rendered may be submitted to Anthem 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 and address of Subscriber
- Identification number
- Patient's name

- Patient's age
- Patient's relationship with the Subscriber
- Other dental coverage in effect
- Date, type and place of service
- Itemization of charges
- Provider's name and address
- Provider's tax ID number
- Your signature and the Physician's signature

Separate Claim Forms Required

A separate claim form is required for each provider for which you are requesting reimbursement. A separate claim form is also required for each member when charges for more than one family member are being submitted.

Out-of-State/Out-of-Area Claim Filing

Members receiving services outside the State can file claims using the same procedures listed above in "Claim Forms". In most instances, covered services received out of state will be provided by a non-Network provider, and dental benefits may or may not be reduced depending on the benefits selected by your employer group. Refer to the Summary of Benefits or your employer for details.

Timely Filing Limits

All claims must be filed within 365 days after the date of service. Any claims filed after this time limit may be denied, unless Anthem is satisfied that there is a valid reason why the member could not submit his/her claim within this time limit.

If a claim must be returned to the Subscriber for additional information, the claim must be resubmitted to Anthem within 90 days of the date the claim was returned to the Subscriber.

If a member's coverage under Certificate ends, claims for covered expenses incurred during the Member's final Benefit Year must be filed within 180 days after the date of the coverage termination. Failure to file a claim within the 180 days will result in loss of benefits otherwise provided by this dental Certificate if, as a result of such failure by the member, Anthem is unable to perform adequate claims review.

Notice of Privacy Practices

We are committed to protecting the confidential nature of your medical information to the fullest extent of the law. In addition to various laws governing your privacy, We have our own privacy policies and procedures in place designed to protect your information. We are required by law to provide individuals with notice of Our legal duties and privacy practices. To obtain a copy of this notice, visit Our website at www.anthem.com or contact Our customer service department.

Explanation of Benefits

After you receive dental care, you will often receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Anthem 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 Provisions

Entire Contract

This Certificate, the Group Contract, the Group application, any Riders, Endorsements or Attachments, and the individual applications of the Subscriber and Dependents, if any, constitute the entire Contract between Anthem and the Group and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to Anthem by the Group and any and all statements made to the Group by Anthem are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Certificate, shall be used in defense to a claim under this Certificate.

Form or Content of Certificate

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

Cessation of Operations

In the event of the cessation of operations or dissolution of Anthem, this Certificate may be terminated immediately by Anthem. Anthem will be obligated for services for the remainder of the period in which Premiums were prepaid or as otherwise prescribed by law.

Disagreement with Recommended Treatment

Each Member enrolls with Anthem 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 Medically Necessary and appropriate 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 Anthem, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of Anthem for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of Anthem

In the event of circumstances not within the control of Anthem, 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 Anthem, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of dental care services provided under this Certificate is delayed or rendered impractical, Anthem shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, Anthem and Network Providers shall render dental care services provided under this Certificate insofar as practical, and according to their best judgment; but Anthem 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 Anthem are determined before or after those of another Plan. The benefits of Anthem:

- Will not be reduced when, under the Order of Benefit Determination Rules, Anthem determines its benefits before another Plan; but
- 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 Anthem."

Definitions

Plan - Anthem and any other arrangement providing dental care or benefits for dental care through:

- 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.
- Coverage under a governmental plan or coverage required or provided by law except Medicaid.
- 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.
- 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:

- Group or group-type hospital indemnity benefits of \$100.00 per day or less.
- 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 Anthem is a Primary Plan or Secondary Plan as to another Plan covering the person.

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

When Anthem 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, Anthem may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Allowable Expense – a necessary, reasonable, and customary item of expense for 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 will be considered both an Allowable Expense and a benefit paid.

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

Order of Benefit Determination Rules

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

- The other Plan has rules coordinating its benefits with those of Anthem; and
- Both those rules and Anthem’s rules require that Anthem’s benefits be determined before those of the other Plan.

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

- **Non-Dependent/Dependent.** The benefits of the Plan which covers the person as a Subscriber or Member (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent, except that: if the person is also a Medicare beneficiary, and as a result of the rules established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - Secondary to the Plan covering the person as a dependent; and
 - Primary to the Plan covering the person as other than a dependent (e.g. a retired employee);
 - then the order of benefits is reversed so that the Plan covering the person as an employee, Member, Subscriber or retiree is secondary and the other Plan is primary.

- **Dependent Child/Parents not Separated or Divorced.** Except as stated below, when Anthem and another Plan cover the same child as a Dependent of parents who are not separated or divorced:
 - The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but
 - If both parents have the same birthday, the benefits of the Plan that covered one parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.
 - However, if the other Plan does not have the rule described in a. immediately above, but instead has a rule based upon the gender of the parent, then the father's coverage pays first.
- **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:
 - First, the Plan of the parent with custody of the child;
 - Then, the Plan of the spouse of the parent with custody of the child; and
 - Finally, the Plan of the parent not having custody of the child.

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

- **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/dental care expenses of the child, the Plans covering the child shall follow the Order of Benefit Determination Rules outlined above.
- **Active/Inactive Subscriber.** If the member who received care is covered as an active employee under one coverage and as an inactive employee under another, the coverage through active employment pays first. Likewise, if a member is covered as the dependent of an active employee under one coverage and as the dependent of the same but inactive employee under another, the coverage through active employment pays first. If the other Plan does not have this rule and if, as a result, Anthem does not agree on the order of benefits, the Longer/Shorter Length of Coverage Rule applies.
- **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:
 - First, the benefits of a Plan covering the person as a Subscriber or Member or as that person's Dependent;
 - 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.
- **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the Plan that covered the person longer are determined before those of the Plan that covered that person for the shorter term.

Effect on Anthem's Benefits

When a Member is covered under two or more Plans which together pay more than the Allowable expense, the Plan will pay Anthem's benefits according to the Order of Benefit Determination Rules. This Certificate's benefit payments will not be affected when it is primary. However, when this Certificate 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 100 percent of the Allowable Expense.

Right to Receive and Release Needed Information

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

Facility of Payment

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

- The persons it has paid or for whom it has paid;
- Insurance companies; or
- Other organizations.

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

Physical Examination

Anthem 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 this Certificate are not designed to duplicate any benefit including work-related injuries, illnesses, or conditions for which Members are eligible under the Worker’s Compensation Law. All sums paid or payable by Worker’s Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to Anthem to the extent Anthem 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 Anthem to be the primary payor, the benefits under this Certificate shall not duplicate any benefits to which Members are entitled or for which they are eligible under any other governmental program. To the extent Anthem 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 Anthem.

Subrogation/Reimbursement

When Anthem pays for your care and you have the right to recover those expenses from the person or organization causing your injury, you agree that Anthem has the right of subrogation to recover the total amount of benefits Anthem has paid. Anthem will have first priority in the payment. Anthem are subrogated to any right you may have to recover from another, his/her insurer, or under any "Uninsured Motorist," "Underinsured Motorist," "Medical/dental Payments," "No-Fault" or other similar coverage provisions. You also agree Anthem can exercise Anthem’s right to direct recovery against you. You must hold in trust for Anthem the proceeds of any recovery, to be paid to Anthem immediately upon the recovery coming into your hands. You must reimburse Anthem, in first priority, to the extent of payments made.

The subrogation right and right of reimbursement apply to amounts recovered through a lawsuit or a settlement with any third party or insurer, regardless of how you or your representative characterize the recovery.

You have the legal obligation to help recover the amounts paid, and you must do nothing that would prejudice Anthem’s subrogation and/or reimbursement rights. You must provide Anthem any information requested by Anthem within five days of the request. You must notify Anthem if you file a personal injury claim, consult an attorney, or bring action against a third party, and must send Anthem copies of any police report or other papers received in connection with the accident or incident resulting in personal injury to you and execute necessary documents to assist Anthem. You may not settle or compromise any claim unless Anthem is notified in writing at least thirty days before such settlement or compromise and Anthem agrees to it in writing. Anthem may suspend the payment of claims under this Certificate in the event you fail to cooperate with Anthem’s efforts.

Right of Recovery

Whenever payment has been made in error, Anthem will have the right to recover such payment from you or, if applicable, the Provider. Anthem reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

Relationship of Parties (Group-Member-Anthem)

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

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

Members' Obligation to Supply Information and Cooperate

The member must provide Anthem with any information Anthem considers necessary to determine whether, or to what extent, services are covered under this certificate, or to carry out the other provisions of this certificate.

The member agrees to cooperate at all times (including while the member is hospitalized) by allowing Anthem access to the member's medical records to investigate claims and verify information provided in the member's Enrollment Application/Change Form and/or Health Statement.

If the member does not supply information or cooperate as described above, Anthem may deny the claims subject to investigation and anthem, where permitted by law may terminate the member's coverage.

Anthem Blue Cross and Blue Shield Note

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Certificate constitutes a contract solely between the Group and Anthem Blue Cross and Blue Shield (Anthem), and that Anthem is the trade name of Rocky Mountain Hospital and Medical Services, Inc. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

Notice

Any notice given under this Certificate shall be in writing. The notices shall be sent to: The Group at its principal place of business; to you at your address as it appears on the records or in care of the Group.

Amendment

Anthem reserves the right to amend or modify the Group Contract and Certificate. No such change will be effective until 30 days after Anthem provides written notice to the Group about the change.

Modifications

By this Certificate, the Group makes Anthem coverage available to eligible Members. However, this Certificate shall be subject to amendment, modification, and termination in accordance with any of its provisions, the Group Contract, or by mutual agreement between Anthem and the Group without the consent or concurrence of any Member. By electing dental coverage under Anthem or accepting Anthem 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 State Law

Any provision of Anthem that is in conflict with the laws of the state in which it is issued is hereby amended to conform to the minimum requirements of such laws.

Clerical Error

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

Policies and Procedures

Anthem may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Certificate with which a Member shall comply.

Waiver

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

Anthem's Sole Discretion

Anthem may, at its sole discretion, cover services and supplies not specifically covered by the Certificate. This applies if Anthem determines such services and supplies are in lieu of more expensive services and supplies that would otherwise be required for the care and treatment of a Member.

The Plan may use prudent business judgment by making limited exceptions to the terms of this Benefit Certificate. When the cost of equivalent services from different providers or suppliers varies significantly, the Plan may take these variations into consideration in determining benefits. These decisions are made only after establishing the cost effectiveness of a medically necessary service and with the understanding of the affected member. Any decisions do not, however, prevent the Plan from administering this dental Plan in strict accordance with its terms in other situations.

Administration

Anthem, or anyone acting on Anthem's behalf, shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation and administration of this Certificate. This includes, without limitation, the power to construe the Contract and Certificate, to determine all questions arising under this Certificate, and to make, establish and amend the rules and regulations and procedures with regard to the interpretation and administration of the provisions of this Certificate. However, these powers shall be exercised in such a manner that has a reasonable relationship to the provisions of the Contract and Certificate. A specific limitation or Exclusion will override more general benefit language.

Headings

The headings and captions in this Certificate are not to be considered a part of this Certificate and are inserted only for purposes of convenience.

Complaint, Appeal and Grievance Procedure

This section explains what to do if a member disagrees with Anthem's denial, in whole or in part, of a claim, requested service or supply and includes instructions on initiating a complaint, filing an appeal or filing a grievance with Anthem.

Complaints

If a member has a complaint about any aspect of Anthem's service or claims processing, the member should contact Anthem's customer service department. A trained representative will work to clear up any confusion and resolve the member's concerns. A member may submit a written complaint to the address listed below. If the member is not satisfied with the resolution of their concerns by the Anthem customer service associate, the member may file an appeal as explained under the heading *Appeals* in this section:

Anthem
Customer Service Department
P.O. Box 9274
Oxnard, CA 93031-9274

Appeals

Your appeal must be submitted in writing. While Anthem encourages you to file appeals within 60 days of the adverse benefit determination, your written appeal must be received by Anthem within 180 days of the adverse benefit determination. Appeals may be for pre-service denials or post-service denials. Anthem will assign a customer advocate to assist you in the appeal process. You must send written appeals to the following address:

Anthem
Appeals Department
P.O. Box 9274
Oxnard, CA 93031-9274

An appeal may be filed with or without first submitting a complaint. In the appeal, you must state plainly the reason(s) why the claim or requested service or supply should not have been denied. You should include any documents not originally submitted with the claim or request for the service or supply and any information that may have a bearing on our decision.

For a thorough, unbiased review, you may access two internal levels of appeal. In the case of a benefit denial based on utilization review, an independent external review appeal is also available to you. For pre-service denials based on utilization review, an expedited appeal and expedited independent external review may be available in certain circumstances.

You may designate a representative (e.g., your Physician or anyone else of your choosing) to file any level of appeal review with us on your behalf. You must give this designation to us in writing.

The Appeals process is governed by laws and regulations, and may be modified from time to time by Anthem as those laws may require. A more detailed description of the Appeals process and the decision timeframes is set forth in our appeals guide. This guide is available through our website or may be obtained free of charge by calling customer service at (877) 811-3106.

Grievances

A member may send a written grievance to the following address:

Anthem
Quality Management Department
P.O. Box 9277
Oxnard, CA 93031-9277

Receipt of the member's grievance will be acknowledged by Anthem's Quality Management Department and the grievance will be investigated by Anthem's Quality Management Department. Anthem treats each grievance investigation in a strictly confidential manner.

Legal Action

Before you take legal action on a claim decision:

- You must first follow the appeal process outlined above in **Complaints and Appeals**.
- You must meet all the requirements of this Certificate.
- No action in law or in equity shall be brought to recover on this Certificate prior to expiration of 60 calendar days after written proof of loss has been filed in accordance with the requirements of this Certificate. No such action shall be brought at all unless brought within three years of the time within which written proof of loss has been filed as required by the Certificate.

Dental Services

Anthem is not liable for the furnishing of Covered Services, but merely for the payment of them. You shall have no claim against Anthem for acts or omissions of any Provider from whom you receive Covered Services. Anthem 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 Anthem receives the claim or other request for benefits and within three years of Anthem's final decision on the claim or other request for benefits. If Anthem decides an appeal is untimely, Anthem's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust Anthem's internal appeals procedure before filing a lawsuit or other legal action of any kind against Anthem.

Division of Insurance Inquiries

For inquiries about health care coverage in Colorado, you may call the Division of Insurance between 8:00 a.m. and 5:00 p.m., Monday through Friday, at (303) 894-7490, or write to the Division of Insurance to the attention of the ICARE Section, 1560 Broadway, Suite 850, Denver, Colorado 80202.

Notice of Privacy Practices



Notice of Privacy Practices



THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: April 14, 2003

THIS PRIVACY NOTICE IS PROVIDED BY Rocky Mountain Hospital and Medical Service, Inc. d/b/a Anthem Blue Cross and Blue Shield (“Anthem”).

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law. We are required by HIPAA to provide you with this notice. This notice describes our privacy practices, legal duties, and your rights concerning your Protected Information. We must follow the privacy practices described in this notice while it is in effect. This notice takes effect **April 14, 2003**. It will remain in effect unless and until we publish and issue a new notice.

1. Our Commitment to Your Privacy

As a company responsible for the information that we collect about you, your privacy is important to us. We are committed to protecting the confidential nature of your medical information to the fullest extent of the law. In addition to various laws governing your privacy, we have our own privacy policies and procedures in place. These are designed to protect your information. We understand how important it is to protect your privacy. We will continue to make this a priority.

2. Our Legal Duties

We are required by applicable federal and state laws to keep certain information about you private. An example of this is your medical information. We treat your medical and demographic information that we collect as part of providing your coverage, as “Protected Information.” It is our policy to maintain the privacy of Protected Information in accordance

with HIPAA, except to the extent that applicable state law provides greater privacy protections. This Notice of Privacy Practices was drafted to be consistent with the HIPAA privacy regulation. Any terms not defined in this Notice will have the same meaning as they have in the HIPAA privacy regulation.

The HIPAA Privacy Regulations generally do not “preempt” (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a state, or other federal laws, rather than the HIPAA Privacy Regulation, might impose a privacy standard that we are required to follow. For example, where such laws are in place, we will follow more stringent state privacy laws that relate to use and disclosure of Protected Information about HIV or AIDS, mental health, substance abuse, chemical dependency, genetic testing, reproductive rights, etc.

We reserve the right to change the terms of this notice. We may make the new notice provisions effective for all the Protected Information that we maintain. This includes information that we created or received before we made the changes. Any revised notice will be provided to you by one of the following means. (1) By mail to the named insured under the terms of your coverage. (2) By delivery of the notice by the named insured’s employer if you are enrolled in employer-sponsored group insurance coverage. A copy of any revised notice will also be available on Anthem’s web site.

Anyone may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact the appropriate office listed at the end of this notice.

3. Our Primary Uses and Disclosures of Your Protected Information

We may use and disclose your Protected Information without your specific authorization for the purposes of treatment, payment, and health care operations. To illustrate:

- **Treatment Activities.** Activities performed by a health care provider related to the provision, coordination or management of health care provided to you. We do not provide treatment, which is the role of a health care provider (your physician, a hospital or the like). However, we may disclose Protected Information to your health care provider in order for that provider to treat you.
- **Payment Activities.** Activities undertaken to obtain premiums or to determine or fulfill our responsibilities for coverage and provision of plan benefits. These include activities such as determining eligibility or coverage, utilization review activities, billing, claims management, and collection activities. For example, we may use Protected Information to determine whether a particular medical service given or to be given to you is covered under the terms of your coverage. We may also disclose Protected Information to health care providers or other health plans for their payment activities, such as to coordinate benefits.
- **Health Care Operation Activities.** Activities such as credentialing, business planning and development, quality assessment and improvement, premium rating, enrollment, underwriting, claims processing, customer service, medical management, fraud and abuse detection, obtaining legal and auditing services, and business management. For example, we may use your Protected Information for underwriting, premium rating or other activities associated with the creation, renewal or replacement of a contract of health insurance or health benefits.

We may also use your Protected Information to give you information about one of our disease/care management programs. We may

also give you information about treatment alternatives or other health-related benefits and services that may interest you. If you are enrolled with Anthem through an employer-sponsored group health plan, we or your group health plan may disclose Protected Information to the sponsor of the plan, provided that the group health plan adopts certain protections required by federal law.

When using and disclosing your Protected Information in our payment and health care operation activities, we may only request, use, and disclose the minimum amount of your Protected Information necessary to complete the activity.

We may contract with others to assist us with treatment, payment or health care operation activities that involve the use of your Protected Information. Such third parties are referred to as our business associates. We require business associates to agree, in writing, to contract terms. These terms are specifically designed to safeguard Protected Information before it is shared with them. We may also have business associates assist in the activities described in the following section that involve permitted uses and disclosures.

4. Other Uses and Disclosures of Your Protected Information

You and on Your Authorization. We must disclose your Protected Information to you. This is described in the Individual Rights section of this notice, below. You may also give us written authorization to use or disclose your Protected Information to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we may not use or disclose your Protected Information for any reason except as described in this notice.

The following is a description of other possible ways we may (and are permitted by law to) use and/or disclose your Protected Information without your specific authorization.

- **Family and Friends.** If you are unavailable to agree, we may disclose your Protected Information to a family member, friend or other person when the situation indicates that disclosure would be in your best interest. This includes a medical emergency or disaster relief. If you are available and agree, we may disclose your Protected Information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.
- **Public Health and Safety.** We may disclose some of your Protected Information permitted by state law to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. We may disclose your Protected Information to a government agency that oversees the health care system or government programs or its contractors, and to public health authorities for public health purposes. We may disclose your Protected Information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.
- **Required by Law.** We may use or disclose your Protected Information when we are required to do so by law. For example, we must disclose your Protected Information to the U.S. Department of Health and Human Services upon request in order to determine if we are in compliance with federal privacy laws. We may disclose your Protected Information to comply with workers' compensation or similar laws.
- **Legal Process and Proceedings.** We may disclose your Protected Information in response to a court or administrative order, subpoena, discovery request, or other lawful process. These disclosures are subject to certain administrative requirements imposed by the HIPAA privacy regulation and permitted by state law.
- **Law Enforcement.** We may disclose limited information to a law enforcement official concerning the Protected Information of a suspect, fugitive, material witness, crime

victim or missing person subject to certain administrative requirements approved by the HIPAA privacy regulation and permitted by state law.

5. Individual Rights

- **Access.** You have the right to inspect and obtain copies of your Protected Information for as long as your information is maintained in our designated record set. Our designated record set includes records from our enrollment, billing, claims, and medical management systems, as well as any other records we maintain in order to make decisions about your health care benefits. Your right of access to Protected Information does not extend to certain information. This includes information contained in psychotherapy notes or information compiled in reasonable anticipation of, or for use in a civil, criminal or administrative proceeding.

You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. We reserve the right to charge a reasonable fee for copies of Protected Information that we provide.

Any request to exercise your individual right of access to your Protected Information must be in writing. You may obtain a form to request access by using the contact information listed at the end of this notice. We will respond to your request for access within 30 days of receiving the request. If all or any part of your request is denied, our response will detail any appeal rights you may have with respect to that decision.

Notwithstanding the formal process for your right of access, certain information related to enrollment and claims processing may be available to you by contacting our Customer Service representatives as part of our normal customer service function. You should contact Customer Service first to see if your request can be satisfied as a customer service request.

- **Amendment.** You have the right to request that we amend your Protected Information that we keep in our designated record set if you believe it is inaccurate. A request that your Protected Information be amended must be done in writing. You may obtain a form to request amendment by using the contact information listed at the end of this notice. We will respond to your request for amendment within 60 days of receiving the request.

If we accept your request to amend the information, we will notify you. We will make reasonable efforts to inform other persons, including those identified by you as having received your Protected Information and needing the amendment. We will also include the changes in any future disclosure of that information. If we deny your request for reasons permitted by the HIPAA privacy regulations, our notice to you will explain any appeal rights you may have with respect to that decision.

Notwithstanding the formal process for your right of amendment, certain information related to enrollment and claims processing may be corrected by contacting our Customer Service representatives. This is part of our normal customer service function. You should contact Customer Service first to see if your request can be satisfied as a customer service request.

- **Disclosure Accounting.** You have the right to request and receive an accounting of disclosures of your Protected Information made by us. We are not required under the HIPAA privacy regulation to provide you with an accounting of certain types of disclosures. The most significant types include:
 - Any disclosures made prior to April 14, 2003
 - Disclosures for treatment, payment or health care operations activities
 - Disclosures to you or pursuant to your authorization
 - Disclosures to persons involved in your care

- Disclosures for disaster relief, national security or intelligence purposes
- Disclosures that are incidental to a permitted use or disclosure

To request an accounting of disclosures, you must send a written request to the contact office listed at the end of this notice. You may request one such accounting at no charge every 12 months. You may request that the accounting cover up to a 6-year period of reportable disclosures from the date of your request. We will respond within 60 days of your request. We reserve the right to impose a reasonable charge for requests made more than once per year.

- **Confidential Communications.** You may believe that you will be in danger if we communicate Protected Information to you to your address of record. If so, you have the right to request that we communicate with you about your Protected Information at an alternative location or by alternate means.

We will make reasonable efforts to accommodate your request if you specify an alternate address. To request a confidential communication, you must direct your request to the contact office listed at the end of this notice.

- **Restriction Request.** You have the right to request that we restrict the use or disclosure of your Protected Information for treatment, payment or health care operation activities. You also have the right to request that we restrict disclosures to relatives, friends, or other individuals that may be involved in your care or payment for your health care. We are not required to agree to such a request for restriction. To request a restriction, you must direct your request to the contact office listed at the end of this notice.

6. Contacting Us

Please contact Anthem Customer Service using the contact information on your ID card:

- If you want a printed copy of our current notice
- If you want to access your Protected Information
- If you want to request an amendment to your Protected Information
- If you want to request an accounting of our disclosures of your Protected Information
- If you want us to communicate with you at an alternative address or by alternate means because you believe that you are endangered
- If you want to request a restriction on our use and disclosure of your Protected Information

If you have questions, concerns, or complaints about this notice or our privacy practices, please contact:

West Privacy Operations Unit
(303) 831-2900
(800) 331-6170

As described in section 5 of this notice, you may also be able to access or amend certain information in our enrollment, billing, or claims systems by contacting Customer Service using the contact information on your ID card.

7. Contacting the Department of Health and Human Services

You may also submit a written complaint to the Department of Health and Human Services if you believe your privacy rights have been violated.

Anthem maintains and enforces a policy of non-retaliation against our members, members of our workforce, or members of the public who bring breaches (or potential breaches) of this notice to the attention of our privacy officer or the Department of Health and Human Services.