Dental Certificate of Coverage

Indiana State Personnel Department

State of Indiana

Group Number 400787

Anthem Dental Classic
Complete Dental Program

Effective January 1, 2021

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

Invest In Your Health

DENTAL CERTIFICATE OF COVERAGE

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

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

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

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

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

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

Questions regarding your policy or coverage should be directed to:

Anthem Blue Cross and Blue Shield

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.

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DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

Dependent – Eligible Dependents are: Your legal spouse; and Children as defined in this Certificate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SUMMARY OF BENEFITS

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

Coverage Year:	Calendar Year
Dependent Age Limit:	To the end of the month in which the child attains age 26.
Benefit Waiting Period:	There are no benefit waiting periods.

DENTAL COVERED SERVICES

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

	Participating Dentist	**Non-Participating Dentist**
Diagnostic and Preventive Services*	100%	90%
Basic Restorative Services	80%	70%
Endodontic Services	80%	70%
Periodontic Services	80%	70%
Oral Surgery Services	80%	70%
Major Restorative Services	60%	50%
Prosthetic Repair and Adjustment Services	80%	70%
Prosthetic Services	60%	50%
Orthodontic Services*	60%	50%

*Not subject to the Deductible

DENTAL BENEFIT MAXIMUMS (combined for Participating and Non-Participating Dentists)

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

Coverage Year Maximum	$1,500.00 per Member

Orthodontic Services Lifetime Maximum. Your orthodontic benefits are subject to the Orthodontic Services Lifetime Maximum. We will not pay any orthodontic benefits in excess of that amount during a Member's lifetime.

Orthodontic Services Lifetime Maximum	$1,500.00 per Member

DEDUCTIBLES (combined for Participating and Non-Participating Dentists)

You are responsible for satisfying the Deductibles before We pay for benefits. Only charges that are considered a Maximum Allowed Amount will apply toward satisfaction of the Deductibles. **Exception:** The Deductible does not apply to Diagnostic and Preventive and Orthodontic Services.

Per Member	$50.00
Per Family	$150.00

Deductible Carryover Provision. If your Deductible is not met in a given Coverage Year, the Maximum Allowed Amount incurred during the last three (3) months of the Coverage Year and applied toward the Deductible for that Coverage Year will also be applied to your Deductible for the next Coverage Year.

ELIGIBILITY AND ENROLLMENT

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

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

Eligibility

- All active, full-time employees and their eligible "dependents" are eligible to participate. For the purpose of benefits eligibility, full-time employees are defined as active employees whose regular work schedule is at least 37 1/2 hours per week.

- All appointed or elected officials and their eligible "dependents".

- Employees eligible under the Short and Long Term Disability Program remain eligible during the period of disability.

- "Dependent" means:

  (a) Spouse of an employee;
  (b) Any children, step-children, foster children, legally adopted children of the employee or spouse, or children who reside in the employee's home for whom the employee or spouse has been appointed legal guardian or awarded legal custody by a court, under the age of twenty-six (26). Such child shall remain a "dependent" for the entire calendar month during which he or she attains age twenty-six (26).
  In the event a child:
  i) was defined as a "dependent", prior to age 19, and
  ii) meets the following disability criteria, prior to age 19:
  (I) is incapable of self-sustaining employment by reason of mental or physical disability,
  (II) resides with the employee at least six (6) months of the year, and
  (III) receives 50% of his or her financial support from the parent
  such child's eligibility for coverage shall continue, if satisfactory evidence of such disability and dependency is received by Anthem in accordance with Anthem's disabled dependent certification and recertification procedures. Eligibility for coverage of the "Dependent" will continue until the employee discontinues his coverage or the disability criteria is no longer met. A Dependent child of the employee who attained age 19 while covered under another Health Care policy and met the disability criteria specified above, is an eligible Dependent for enrollment so long as no break in Coverage longer than sixty-three (63) days has occurred immediately prior to enrollment. Proof of disability and prior coverage will be required. The plan requires periodic documentation from a physician after the child's attainment of the limiting age.

- A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Legislator", dependent or spouse as defined and pursuant to the conditions set forth in IC 5-10-8.

- "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

  (a) Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;
  (b) Must have completed twenty (20) years of public service, ten (10) years of which must be continuous State service immediately preceding retirement;
  (c) Must have fifteen (15) years of participation in a retirement fund.

- "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

  (a) Must retire after December 31, 2006;
  (b) Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;
  (c) Must have completed fifteen (15) years of public service, ten (10) years of which must be continuous State service immediately preceding retirement.

- "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

  (a) Must have been employed as a teacher in a State institution under IC 11-10-5, IC 12-24-3, IC 16-33-3, or IC 16-33-4;
  (b) Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;
  (c) Must have fifteen (15) years of service credit as a participant in the retirement fund of which the employee is a member on or before the employee's retirement date; or must have completed ten (10) years of service credit as a participant in the retirement fund of which the employee is a member immediately before the employee's retirement;

- A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Judge" who meets the following:

  (a) Retirement date is after June 30, 1990;
  (b) Will have reached the age of sixty-two (62) on or before retirement date;
  (c) Is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.;
  (d) Who has at least eight (8) years of service credit as a participant in the Judge's retirement fund, with at least eight (8) years of service credit completed immediately preceding the Judge's retirement.

- A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Prosecuting Attorney" who meets the following:

  (a) Who is a retired participant under the Prosecuting Attorney's Retirement fund;
  (b) Whose retirement date is after January 1, 1990;
  (c) Who is at least sixty-two (62) years of age;
  (d) Who is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.; and
  (e) Who has at least ten (10) years of service credit as a participant in the Prosecuting Attorneys retirement fund, with at least ten (10) years of service credit completed immediately preceding the participant's retirement.

- Retirees eligible under subsections 6 – 10 must file a written request for the coverage within ninety (90) days after retirement. At that time, the retiree may elect to have the retiree's spouse covered. The spouse's subsequent eligibility to continue insurance under the surviving spouse's eligibility end on the earliest of the following:

    (a) Twenty-four (24) months from the date the deceased Retirees coverage is terminated. At the end of the period the Spouse would be eligible to remain covered until the end of the maximum period under COBRA;
    (b) When the Spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.
    (c) The end of the month following remarriage; or
    (d) As otherwise provided by Act of the General Assembly.

- Employee on a leave of absence for ninety (90) days or less and out of pay status.

- An employee on family medical leave.

- Retirees eligible under IC 5-10-12.

- As otherwise provided by Act of the Indiana General Assembly.

Continuation of Health Benefits While in Out-Of-Pay Status

When you are in out-of-pay status for a Family Medical Leave absence, coverage will continue through the duration of the approved leave of absence with no lapse in coverage. When returning to in-pay status, premiums missed during the time spent out-of-pay status will be paid through payroll deductions. In the event payroll deductions cannot occur, you will be billed directly at home by the Plan for premiums due. Failure to submit payment will result in termination of coverage retroactive to the last day of coverage for which full payment was received. If coverage is terminated for non-payment of premium, you will be responsible for any claims incurred in the affected benefit timeframe.

For all other type of leaves resulting in out-of-pay status, during the period of continued eligibility, you will be billed directly at home by the Plan for premiums due. When billed at home, premiums must be paid by the due date on the billing to ensure continuation of coverage. Failure to submit payment will result in termination of coverage retroactive to the last day of coverage for which full payment was received. If coverage is terminated for non-payment of premium, you will be responsible for any claims incurred in the affected benefit timeframe. Employees and their dependents that have lost coverage due to non-payment of premiums are not eligible for continuation of coverage through COBRA.

Open Enrollment

The Open Enrollment under this Contract shall be held annually.

Family Status Change

Your benefit elections are intended to remain the same for the entire Coverage Year. During the Coverage Year, you will be allowed to change your benefits only if you experience an eligible Family Status Change which includes:

- Change in legal marital status such as marriage or divorce.
- Change in number of Dependents in the event of birth, adoption, or death.
- Change in your or your spouse's employment – either starting or losing a job.
- Change in your or your spouse's work schedule, such as going from full-time to part-time or part-time to full-time, or beginning or ending an unpaid leave of absence.
- Change in Dependent status, such as if a child reaches maximum age under the Certificate.

- Become eligible for Medicare, Medicaid or Children's Health Insurance Program (CHIP) coverage.
- Termination of Medicare, Medicaid or Children's Health Insurance Program (CHIP) coverage because you or your Dependents are no longer eligible.
- Loss of other coverage.

Due to federal regulations, the changes you make to your benefits must be consistent with the Family Status Change event that you experience. For example, if you have a baby, it is consistent to add your newborn to your current dental coverage but it is not consistent to drop your dental coverage altogether.

If you experience one of the above eligible Family Status Changes during the year, you have 31 days (except in the case of qualification for or termination of employment assistance under Medicaid/CHIP, in which case the employee has 60 days after the date of eligibility) from the event to change your elections. If you do not change your benefits within 31 days of the event, you will not be allowed to make changes until the next Open Enrollment period. You may obtain a Family Status Change Form by contacting your Employer.

The Group reserves the right to terminate the Contract, in whole or in part, at any time (subject to applicable collective bargaining agreements). Termination of the Contract will result in loss of benefits for all Members. If the Contract is terminated, the rights of the Members are limited to Maximum Allowed Amount for Covered Services incurred before termination.

TERMINATION AND CONTINUATION

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

Termination of Coverage

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

a) On the date determined by your employer in which (1) you cease to be eligible; (2) your Dependent is no longer eligible as a Dependent under the Certificate.

b) On the date the Certificate is terminated.

c) On the date the Group terminates the Certificate by failure to pay the Premiums, except as a result of inadvertent error.

d) The date contribution for coverage under the Certificate is not made when due.

For extended eligibility, see Continuation of Coverage.

Continuation of Coverage (COBRA)

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

QUALIFYING EVENT	WHO MAY CONTINUE	MAXIMUM CONTINUATION PERIOD
Employment ends, retirement, leave of absence, lay-off, or employee becomes ineligible (except gross misconduct dismissal)	Subscriber and Dependents	Earliest of: 1. 18 months, or 2. Enrollment in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Divorce, marriage or civil union dissolution, or legal separation	Former spouse and any Dependent children who lose coverage	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Death of Subscriber	Surviving spouse and Dependent children	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Dependents lose eligibility due to Subscriber's entitlement to Medicare	Spouse and Dependents	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Subscriber's total disability	Subscriber and Dependents	Earliest of: 1. 29 months, or 2. Date total disability ends, or 3. Enrollment date in other group coverage or Medicare.
Retirees of employer filing Chapter 11 bankruptcy (includes substantial reduction in coverage within 1 year of filing)	Retiree and Dependents	Earliest of: 1. Enrollment date in other group coverage, or 2. Death of retiree or Dependent electing COBRA.
Surviving Dependents of retiree on lifetime continuation due to the bankruptcy of the employer	Surviving spouse and Dependents	Earliest of: 1. 36 months following retiree's death, or 2. Enrollment date in other group coverage.

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

1. Choosing Continuation

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

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

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

2. Second qualifying event

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

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

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

3. Terminating Continuation of Coverage – COBRA

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

   a) The expiration of the specified period of time for which Continuation of Coverage – COBRA can be maintained; as mandated by applicable State or Federal law;

   b) This Certificate is terminated by the Group Subscriber;

   c) The Group Subscriber's or Member's failure to make the payment for the Member's Continuation of Coverage

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

DENTAL PROVIDERS AND CLAIMS PAYMENT

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

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

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

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

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

When you receive Covered Services from a Dentist, We will apply processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the Dental Procedure. Applying these rules may affect Our determination of the Maximum Allowed Amount. For example, your Dentist may have submitted the claim using several procedure codes when there is a single procedure code that includes all or a combination of the procedures that were performed. When this occurs, Our payment will be based on a single Maximum Allowed Amount for the single procedure code rather than a separate Maximum Allowed Amount for each billed procedure amount.

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

PROVIDER NETWORK STATUS

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

Participating Dentists

A Participating Dentist is a Dentist who has signed a written provider service agreement agreeing to service the program identified in this Certificate. For Covered Services performed by a Participating Dentist, the Maximum Allowed Amount is based upon the lesser of the Dentist's actual charges or the Schedule of Maximum Allowable Charges. Because Participating Dentists have agreed to accept the Maximum Allowed Amount as payment in full for services, they should not send you a bill or collect for amounts above the agreed upon Maximum Allowed Amount. However, you may receive a bill or be asked to pay a portion of the Maximum Allowed Amount to the extent you have exhausted your coverage for the service, have not met your Deductible, have a Coinsurance, have received non-covered services, or have exceeded the dental benefit maximum as outlined in the Summary of Benefits. Please call Our Customer Service Department at (877) 604-2142 for help in finding a Participating Dentist or visit Our website at www.anthem.com/mydentalvision.

Non-Participating Dentists

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

Unlike Participating Dentists, Non-Participating Dentists may send you a bill and collect for the amount of the Dentist's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Non-Participating Dentist charges. This amount may be significant. Choosing a Participating Dentist will likely result in lower out of pocket costs to you. Please call Customer Service Department at (877) 604-2142 for help in finding a Participating Dentist or visit Our website at www.anthem.com/mydentalvision.

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

MEMBER COST SHARE

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

Payment of Benefits

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

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

THE MEMBER IS RESPONSIBLE FOR ALL TREATMENT CHARGES MADE BY A NON-PARTICIPATING DENTIST. WHEN SERVICES ARE OBTAINED FROM A NON-PARTICIPATING DENTIST, ANY BENEFITS PAYABLE UNDER THE GROUP CONTRACT ARE PAID DIRECTLY TO THE MEMBER UNLESS YOU ASSIGN THE PAYMENT DIRECTLY TO THE PROVIDER OF THE DENTAL SERVICE BY INDICATING SO ON THE CLAIM FORM.

Notice of Claim

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

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

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

Claims should be submitted to:

Anthem Blue Cross and Blue Shield
PO Box 1115
Minneapolis, MN 55440-1115
(877) 604-2142

Proof of Claim

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

Claim Forms

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

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

Member's Cooperation

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

Explanation of Benefits

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

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

COVERED SERVICES

Pretreatment Estimate
(Estimate of Benefits)

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

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

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

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

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

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

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

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

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

PREVENTIVE CARE
(Diagnostic & Preventive Services)

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

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

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

Radiographs (X-rays)

- **Bitewings** – Covered at 1 series of bitewings per calendar year.
- **Full Mouth (Complete Series) or Panoramic** – Covered 1 time per 36-month period.
- **Periapical(s)** – 4 single x-rays are covered per 12-month period.
- **Occlusal** – Covered at 2 series per 24-month period.

Dental Cleaning

- **Prophylaxis** – Any combination of this procedure or periodontal maintenance (see Periodontics section) is covered 2 times per calendar year.

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

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

Fluoride Treatment (Topical application of fluoride) – Covered 1 time per 12-month period for dependent children through the age of 13.

Sealants or Preventive Resin Restorations – Any combination of these procedures is covered 1 time per lifetime for permanent first and second molars of eligible dependent children through the age of 15.

Space Maintainers – Covered through the age of 18.

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

EXCLUSIONS – Coverage is NOT provided for:

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

BASIC SERVICES

Restorations

- **Amalgam (silver) Restorations** – Treatment to restore decayed or fractured permanent or primary teeth.
- **Composite (white) Resin Restorations**
  - **Anterior (front) Teeth** – Treatment to restore decayed or fractured permanent or primary anterior (front) teeth.
  - **Posterior (back) Teeth** – Treatment to restore decayed or fractured permanent or primary posterior (back) teeth.

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

Basic Tooth Extractions

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

Restorative cast post/core – See benefit coverage description under Complex or Major Restorative Services.

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

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

Crown, Inlay, Onlay, and Veneer Repair – Covered 1 time per 12-month period per tooth when the submitted narrative from the treating dentist supports the procedure.

Core build-up, includes any pins – Covered 1 time per 7 year period when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Crown pin retention.

Repairs – Covered 1 per 6-month period:

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

EXCLUSIONS – Coverage is NOT provided for:

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

BASIC ENDODONTIC SERVICES (NERVE OR PULP TREATMENT)

Endodontic Therapy on Primary Teeth

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

Endodontic Therapy on Permanent Teeth

- **Root Canal Therapy**

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

Apicoectomy.

EXCLUSIONS – Coverage is NOT provided for:

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

7. Retrograde filling.
8. Hemisection.

PERIODONTICS (GUM & BONE TREATMENT)

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

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

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

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

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

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

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

EXCLUSIONS – Coverage is NOT provided for:

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

ORAL SURGERY (TOOTH, TISSUE, OR BONE REMOVAL)

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

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

Other Complex Surgical Procedures

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

LIMITATION: The Other Complex Surgical Procedures listed above are covered only when required to prepare for dentures.

Surgical Reduction of Fibrous Tuberosity – Covered 1 time per 6-month period.

Intravenous Conscious Sedation, IV Sedation and General Anesthesia – Covered when performed in conjunction with complex surgical service.

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

Temporomandibular Joint Disorder (TMJ)

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

If you or your dependents are not eligible for TMJ benefits under another insurance program, either medical or dental, dental services for TMJ will be covered under this plan within the noted plan limitations, maximums, deductibles and payment percentages of treatment costs.

LIMITATIONS

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

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

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

EXCLUSIONS – Coverage is NOT provided for:

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

COMPLEX OR MAJOR RESTORATIVE SERVICES (CROWNS, INLAYS AND ONLAYS)

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

Gold foil restorations – Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances. The patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Services and optional treatment, plus any Deductible and/or Coinsurance for the covered benefit. Covered 1 time per 24-month period.

Inlays – Covered 1 time per 24-month period.

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

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

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

Implant Crowns – See Prosthetic Services.

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

Restorative cast post/core – Covered 1 time per 7 year period when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Occlusal guard – Covered 1 time per lifetime.

EXCLUSIONS – Coverage is NOT provided for:

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

PROSTHETIC REPAIR AND ADJUSTMENT SERVICES (DENTURES, PARTIALS, AND BRIDGES)

Tissue Conditioning – Covered 2 times per 36-month period.

Recement Fixed Prosthetic – Covered 1 time per 6-month period.

Reline – Covered 1 per 36-month period:

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

Rebase – Covered 1 per 24-month period:

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

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

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

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

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

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

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

EXCLUSIONS – Coverage is NOT provided for:

1. The replacement of an existing partial denture with a bridge.
2. Initial installation of full or partial dentures, implants or fixed bridgework to replace a tooth (teeth) which was extracted prior to becoming a Member under this plan. EXCEPTION: This exclusion shall not apply for any person who has been continuously covered under this plan for more than 12 months.
3. Coverage for congenitally missing teeth. EXCEPTION: This exclusion shall not apply for any person who has been continuously covered under this dental benefit plan for more than 12 months.
4. Interim removable or fixed prosthetic appliances (dentures, partials or bridges).
5. Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
6. Additional, elective or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments.
7. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
8. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
9. Services or supplies that have the primary purpose of improving the appearance of your teeth.
10. Placement or removal of sedative filling, base or liner used under a restoration.
11. Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.

PROSTHETIC SERVICES (DENTURES, PARTIALS, AND BRIDGES)

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

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

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

- for Members age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if no more than 3 teeth are missing in the same arch;
- a natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- no other missing teeth in the same arch that have not been replaced with a removable partial denture;

- if none of the individual units of the bridge has been benefited previously as a crown or cast restoration in the last 7 years;
- if 7 years have elapsed since the last benefited removable prosthetic appliance (bridge) and the existing bridge needs replacement because it cannot be repaired or adjusted.

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

Single Tooth Implant Body, Abutment and Crown – Covered 1 time per 7-year period for covered persons age 16 and over. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

LIMITATION: Some adjunctive implant services may not be covered. It is recommended that a Pretreatment Estimate be requested to estimate the amount of payment prior to beginning treatment.

EXCLUSIONS – Coverage is NOT provided for:

1. The replacement of an existing partial denture with a bridge.
2. Initial installation of full or partial dentures, implants or fixed bridgework to replace a tooth (teeth) which was extracted prior to becoming a Member under this plan. EXCEPTION: This exclusion shall not apply for any person who has been continuously covered under this plan for more than 12 months.
3. Coverage for congenitally missing teeth. EXCEPTION: This exclusion shall not apply for any person who has been continuously covered under this dental benefit plan for more than 12 months.
4. Interim removable or fixed prosthetic appliances (dentures, partials or bridges).
5. Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
6. Additional, elective or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments.
7. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
8. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
9. Services or supplies that have the primary purpose of improving the appearance of your teeth.
10. Placement or removal of sedative filling, base or liner used under a restoration.
11. Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.

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

ORTHODONTICS

TREATMENT NECESSARY FOR THE PREVENTION AND CORRECTION OF MALOCCLUSION OF TEETH AND ASSOCIATED DENTAL AND FACIAL DISHARMONIES.

Limited Treatment – Treatments which are not full treatment cases and are usually done for minor tooth movement.

Interceptive Treatment – A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.

Comprehensive (complete) Treatment – Full treatment includes all records, appliances and visits.

Removable Appliance Therapy – An appliance that is removable and not cemented or bonded to the teeth.

Fixed Appliance Therapy – A component that is cemented or bonded to the teeth.

Other Complex Surgical Procedures

- **Surgical exposure of impacted or unerupted tooth for orthodontic reasons**
- **Surgical repositioning of teeth**

LIMITATION: Treatment in progress (appliances placed prior to eligibility under this plan) will be benefited on a pro-rated basis.

EXCLUSIONS – Coverage is NOT provided for:

1. Monthly treatment visits that are inclusive of treatment cost;
2. Repair or replacement of lost/broken/stolen appliances;
3. Orthodontic retention/retainer as a separate service;
4. Retreatment and/or services for any treatment due to relapse;
5. Inpatient or outpatient hospital expenses; and
6. Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments: Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. The Member must have continuous eligibility under the plan in order to receive ongoing orthodontic benefit payments.

Benefit payments are made in equal amounts: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or until the lifetime maximum benefits are exhausted (see Benefit Maximums in the Summary of Benefits).

Before treatment begins, the treating dentist should submit a Pre-treatment Estimate. An Estimate of Benefits form will be sent to you and your dentist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the dentist should submit the Estimate of Benefit form with the date of placement and his/her signature. After benefit and eligibility verification by the Plan, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be issued to you and your dentist. This again will serve as the claim form to be submitted 6 months from the date of appliance placement.

Enhanced benefit for Members who are pregnant or who have diabetes

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

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

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

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

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

The enhanced benefit will be available on the first of the month following the date We receive the enhanced benefit enrollment form.

Enhanced benefit for Members who are enrolled in the Anthem Care Management program

Enhanced dental benefits are available for any member enrolled in the Anthem Care Management program who is in active management with an Anthem Care Manager for the following conditions cancer with chemotherapy, head and neck cancer with chemotherapy and/or radiation, solid organ transplant, bone marrow transplant, cardiac conditions (e.g. valve conditions). The enhanced benefits include a maximum of three of the following procedures:

- Prophylaxis; or
- Periodontal Maintenance

Please note enrollment alone does not qualify you for the benefit. You must be in active management of your case with an Anthem Care Manager.

Exclusions
Coverage is NOT provided for:

a) Dental services which a Member would be entitled to receive for a nominal charge or without charge if this Plan were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Member receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this Plan will not be reduced or denied because dental services are rendered to a subscriber or dependent who is eligible for or receiving Medical Assistance.

b) Dental services or health care services not specifically covered under the Group Dental Plan Contract (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).

c) New, experimental or investigational dental techniques or services may be denied until there is, to the satisfaction of the Plan, an established scientific basis for recommendation.

d) Dental services performed for cosmetic purposes.

e) Dental services completed prior to the date the Member became eligible for coverage.

f) Services of anesthesiologists.

g) Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.

h) Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

i) Dental services performed other than by a licensed dentist, licensed physician, his or her employees.

j) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

k) Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.

l) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.

m) Orthodontic treatment services, unless specified in this Certificate as a covered dental service benefit.

n) Case presentations, office visits and consultations.

o) Incomplete, interim or temporary services.

p) Initial installation of full or partial dentures, implants or fixed bridgework to replace a tooth (teeth) which was extracted prior to becoming a Member under this plan. EXCEPTION: This exclusion shall not apply for any person who has been continuously covered under this plan for more than 12 months.

q) Corrections of congenital conditions during the first 12 months of continuous coverage under this plan.

r) Athletic mouth guards, enamel microabraision and odontoplasty.

s) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.

t) Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.

u) Bacteriologic tests.

v) Cytology sample collection.

w) Separate services billed when they are an inherent component of a Dental Service.

x) Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).

y) Interim or temporary removable or fixed prosthetic appliances (dentures, partials or bridges).

z) Services for the replacement of an existing partial denture with a bridge.

aa) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.

bb) Provisional splinting, temporary procedures or interim stabilization.

cc) Placement or removal of sedative filling, base or liner used under a restoration.

dd) Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.

ee) Oral hygiene instruction

ff) Occlusal procedures.

gg) Any charges which exceed the Maximum Allowed Amount.

hh) Pulp vitality tests.

ii) Adjunctive diagnostic tests and diagnostic casts.

jj) Incomplete root canals.

kk) Cone beam images.

ll) Anatomical crown exposure.

mm) Temporary anchorage devices.

nn) Sinus augmentation.

oo) Amalgam or composite restorations, inlays, onlays and/or crowns placed for preventive or cosmetic purposes.

pp) Brush biopsy.

Limitations

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

b) Reconstructive Surgery: benefits shall be provided for reconstructive surgery when such dental procedure is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, however that such services are dental reconstructive surgical services.

c) Benefits for inpatient or outpatient expenses arising from dental services up to age 18, including orthodontic and oral surgery services, involved in the management of birth defects known as cleft lip and cleft palate. For programs without orthodontic coverage: Dental orthodontic services not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this dental benefit program. For programs with orthodontic coverage: If coverage for the treatment of cleft lip or cleft palate is available under any other policy or contract of insurance, this plan shall be primary and the other policy or contract shall be secondary.

d) Some procedures are an integral part of another completed service covered by the Plan. If the dentist bills these procedures separately from the covered service, the Plan will disallow coverage for the separately billed procedures. You will then be responsible for any charge for the separately billed procedures and must pay your dentist directly.

Optional Treatment Plans

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

GENERAL PROVISIONS

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reasons please contact your agent. If no agent was involved in the sale of this insurance or if you have any additional questions you may you may contact Anthem at the following address and telephone number: PO Box 1171 Minneapolis, MN 55440-1171 and (877) 604-2142.

Form or Content of Certificate

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

Relationship of Parties (Plan – Participating Dentists)

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

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

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

Not Liable for Provider Acts or Omissions

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

Identification Card

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

Circumstances Beyond the Control of the Plan

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

Coordination of Benefits

Coordination of Benefits (COB) provisions apply when you or members of your family have other coverage through another group insurance plan, such as another Anthem plan, an employer or employee organization plan or coverage required or provided by law.

When you have other coverage, all programs involved will work together to provide the maximum benefits for which you are entitled. Coordinated benefits will never be less than those normally provided under this program.

If you are eligible for benefits through two or more programs, one of the programs will be responsible for "primary coverage". This means full benefits will be provided by the primary coverage program before benefits of the other program will be provided.

The other program will be responsible for "secondary coverage". This means that only after primary coverage benefits have been determined will benefits be available through secondary coverage. Secondary coverage programs will provide benefits only to the extent that the combination of primary and secondary coverage does not exceed the allowable charge.

If the husband and wife both have separate group dental care programs, each offering coverage for spouse and family, COB works this way:

• The husband's program will be primary coverage when he receives care, and the wife's program will be primary coverage when she receives care.

• If the employee is the same person on each program, the program under which he or she has been enrolled for the longer period of time will be primary.

• If one of the programs does not have a COB provision, it will be primary carrier.

• As required by law, if a covered member of your family also has coverage under Medicaid, this plan is always primary.

• If children are covered under both programs, one of the following rules will apply:

1. The program covering the parent with the earlier birthday in the year will be primary. If both parents have the same birthday, the program covering the Dependent for the longer period of time will be primary; OR
2. Some insurance companies always designate the father's policy as the primary carrier for children. If Anthem must coordinate benefits with a company that has that rule, the father's policy will be primary. You will be asked to complete questionnaires from time to time asking about other dental coverage. Please complete and return the questionnaire quickly and let Us know when other insurance coverage changes or is canceled to avoid possible claims denials.

Relationship of Parties (Group-Member-Plan)

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

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

Conformity with Law

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

Modifications

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

Physical Examination and Autopsy

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

Legal Action

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

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

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

Punitive Damages

In the event that you or your representative sue Us or any of Our directors, officers or employees acting in his or her capacity as a director, officer or employee for a determination of what coverage, if any, exists under this Certificate, your damages will be limited to the amount of your claim for benefits.

The damages may not exceed the amount of any claim not properly paid as of the date the lawsuit is filed. This Certificate does not provide coverage for punitive damages, or damages for emotional distress or mental anguish. However, this provision is not intended, and will not be construed, to affect in any manner, any recovery by you or your representative of any non contractual damages to which you or your representative may otherwise be entitled.

Reservation of Discretionary Authority

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

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

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

CLAIM AND APPEAL PROCEDURES

Written Notice of Claim

Written notice of claim must be submitted to Us within twenty (20) days after the date of service. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

Claim Forms

We will furnish to the person making claim, or to the policyholder for delivery to such person, such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of fifteen (15) days after We receive notice of any claim under the policy, the person making such claim shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and the extent of the loss for which claim is made.

Time of Payment of Claim

All claims should be submitted within 12 months of the date of service.

For a claim that is filed electronically, We will notify the provider of any deficiencies in a submitted claim not more than thirty (30) days after receipt of proof of loss and will describe any remedy necessary to establish a clean claim.

For a claim that is filed on paper, We will notify you, or the provider if submitted by the provider, of any deficiencies in a submitted claim not more than forty-five (45) days after receipt of proof of loss and will describe any remedy necessary to establish a clean claim.

If We do not provide notification within the above time frames, the claim will be considered a clean claim and the claim will be paid or denied, within thirty (30) days for a claim that is filed electronically or forty-five (45) days for a claim that is filed on paper.

If We fail to pay or deny a clean claim in the time required above and We subsequently pay the claim, We will pay interest to you, or to the Provider that submitted the claim, on the allowable amount of the claim paid under this provision.

Interest paid accrues beginning thirty-one (31) days after the date the claim is electronically or forty-six (46) days after the date the claim is filed in paper format; and stops accruing on the date the claim is paid.

Interest paid will be equal to the average investment yield on state money for Indiana's previous fiscal year, excluding pension fund investments, as published in the auditor of Indiana's comprehensive annual financial report.

"Clean claim" means a claim submitted for payment that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

Appeals

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

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

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

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

Authorized Representative

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

ANTHEM DENTAL

FOR CLAIMS AND ELIGIBILITY
Anthem Dental Claims
PO Box 188
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FOR APPEALS
P.O. Box 1122
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