



Dental Certificate of Coverage

Greater Clark County Schools

Low Plan

Group Number IN2362

Anthem Dental

Essential Choice

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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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SUMMARY OF BENEFITS

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

Coverage Year	Calendar Year - A 12-month period starting January 1
Dependent Age Limit	To the end of the month in which the child attains age 26.
Benefit Waiting Period	There are no benefit waiting periods.

DENTAL BENEFIT MAXIMUMS

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

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

Coverage Year Maximum \$1000.00 per Member

Accidental Dental Injury Benefit. No member coinsurance, and/or deductible, or waiting period will apply to services received as a result of an Accident. Accidental Dental Injury benefits are subject to the Coverage Year Maximum. An Accident is defined as an injury that results in physical damage or injury to sound natural teeth and/or the supporting hard and soft tissues as a result of extraoral blunt forces and not due to chewing or biting forces. Sound natural teeth are those that were in good repair prior to the accident and were stable, in functional occlusion, free from decay, fracture and advanced periodontal disease at the time of the accident. The initial claim for the Accident and all claims related to the Accident must be submitted within 12 months following the date of the Accident.

DEDUCTIBLES

Deductible (combined for Participating and Non-Participating Dentist)

Participating Dentist

Per Member	\$50.00
Per Family	\$150.00

Non-Participating Dentist

Per Member	\$50.00
Per Family	\$150.00

Exception: The Deductible does not apply to Diagnostic and Preventive Services.

Dental Covered Services

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

	Participating Dentist	Non-Participating Dentist
Diagnostic and Preventive Services*	100%	100%
Basic Restorative Services	50%	50%

*(Not subject to the Deductible)

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.

Accident - An injury that results in physical damage or injury to the sound natural teeth and/or supporting hard and soft tissue structures resulting from extraoral blunt forces and not due to chewing or biting forces. Sound natural teeth are those in good repair that were stable, functional and free from decay, fracture and advanced periodontal disease at the time of the accident.

Accidental Dental Injury Maximum - The maximum dollar amount payable per Accident for Covered Services provided to a Member due to an Accident. Refer to the **Summary of Benefits** for the Accidental Dental Injury Maximum amount.

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

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

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.

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.

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.

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 as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dentist - A person who is licensed to practice dentistry by the governmental authority having jurisdiction

over the licensing and practice of dentistry.

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

Effective Date - The date that a Subscriber's coverage begins under this Certificate. You must be Actively at Work on your Effective Date for your coverage to begin. If you are not Actively at Work on your Effective Date, your Effective Date changes to the date that you do become Actively at Work. 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.

Medically Necessary (Medical Necessity) procedures, services or treatments are those which are:

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

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.

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 the Maximum Allowed Amount 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.

Prior Plan - The plan sponsored by the Group which was replaced by the benefits under this Certificate within 60 days. You are considered covered under the Prior Plan if you: (1) were covered under the Prior Plan on the date that plan terminated; (2) properly enrolled for coverage within 31 days of this Certificate's Effective Date; and (3) had coverage terminate solely due to the Prior Plan's termination.

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.

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

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 periods and Actively At Work standards as determined by the Group or state and/or federal law and approved by Us.

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

Eligibility

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

Subscriber

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

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

Dependents

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

- The Subscriber's spouse. For information on spousal eligibility please contact the Group.
- The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the same or opposite sex who has signed the Domestic Partner Affidavit certifying that: he or she is the Subscriber's or the Eligible Person's sole Domestic Partner and has been for six (6) months or more; he or she is mentally competent; neither the Subscriber nor Eligible Person is related by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Subscriber or Eligible Person.

For purposes of this Certificate, a Domestic Partner shall be treated the same as a spouse, and a Domestic Partner's child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.

Any federal or state law which applies to a Member who is a spouse or child under this Plan shall also apply to a Domestic Partner or a Domestic Partner's child who is a Member under this Plan. This includes but is not limited to, COBRA, FMLA, and COB. A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.

To apply for coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner must complete and sign the Affidavit of Domestic Partnership in addition to the Enrollment Application, and must meet all criteria stated in the Affidavit. Signatures must be witnessed and notarized by a notary public. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.

- The Subscriber's or the Subscriber's spouse's natural children, newborn and legally adopted children, stepchildren, children for whom the Subscriber or the Subscriber's spouse is a legal guardian, or children who the Group has determined are covered under a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.

- The following children, if the Subscriber provides more than fifty percent (50%) of the child's total support: the Subscriber's or the Subscriber's spouse's grandchildren or other blood relatives.

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

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves due to mental, intellectual, or physical disability. The Dependent's disability must start before the end of the period they would become ineligible for coverage. The Plan must certify the Dependent's eligibility. The Plan must be informed of the Dependent's eligibility for continuation of coverage within 120 days after the Dependent would normally become ineligible. You must notify Us if the Dependent's status changes and they are no longer eligible for continued coverage.

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

To obtain coverage for children, We may require that the Subscriber complete a "Dependency Affidavit" and provide Us with a copy of any legal documents awarding guardianship of such child(ren) to the Subscriber. Temporary custody is not sufficient to establish eligibility under this Certificate.

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

College Student Medical Leave

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

Medically Necessary change in student status. The extended coverage is available if a college student would otherwise lose coverage because a serious illness or injury requires a Medically Necessary leave of absence or a change in enrollment status (for example, a switch from full-time to part-time student status).

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

Out of Service Area Dependent Child Coverage

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

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

Enrollment

Initial Enrollment

An Eligible Person can enroll for Single or Family Coverage by submitting an application to the Plan. The application must be received by the date stated on the Group Contract or the Plan's underwriting rules for

initial application for enrollment. Coverage will be effective based on the waiting period chosen by the Group, and will not exceed 90 days.

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

If a person qualifies as a Dependent but does not enroll when the Eligible Person first applies for enrollment, the Dependent can only enroll for coverage during the Open Enrollment period or during a Special Enrollment period, whichever is applicable.

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

Newborn and Adopted Child Coverage

Any Dependent child born while the Subscriber or Member's spouse is eligible for coverage will be covered from birth for a period of 31 days. Any Dependent child adopted while the Subscriber or the Member's spouse is eligible for coverage will be covered from the date of placement for purposes of adoption for a period of 31 days.

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

To continue coverage beyond the 31 day period after the child's birth or adoption you must notify Us by submitting a Change of Status Form to add the child under the Subscriber's Certificate. The Change of Status Form must be submitted within 31 days after the birth or placement of the child. If timely notice is given, an additional Premium for the coverage of the newborn child or adopted child will not be charged for the duration of the notice period. However, if timely notice is not given, We may charge an additional Premium from the child's date of birth or placement for adoption. Even if no additional Premium is required, you should still submit an application / change form to the Group to add the newborn to your Plan, to make sure We have accurate records and are able to cover your claims.

If the child is not enrolled within 31 days of the date of birth or placement for adoption, coverage will cease.

Newborn and Adopted Child Coverage will be for illness and injury, including care or treatment of:

- congenital defects;
- birth abnormalities; or
- premature birth.

Adding a Child due to Award of Legal Custody or Guardianship

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

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child under this Certificate, We will permit your child to enroll at any time without regard to any Open Enrollment limits and shall provide the benefits of this Certificate in accordance with the applicable requirements of such order. A child's coverage under this provision will not extend beyond any Dependent Age Limit listed in the Summary of Benefits. Any claims payable under this

Certificate will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Special Enrollment/Special Enrollees

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

If We receive an application to add your Dependent or an Eligible Person and Dependent more than 31 days after the qualifying event, we will not be able to enroll that person until the Group's next Open Enrollment.

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

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

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination. If We receive an application to add your Dependent or an Eligible Person and Dependent more than 60 days after the loss of Medicaid/CHIP or of the eligibility determination, we will not be able to enroll that person until the Group's next Open Enrollment.

Application forms are available from the Plan.

Open Enrollment Period

The Open Enrollment under this Contract shall be held annually.

Notice of Changes

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

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

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

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

the right to bill the Subscriber for the cost of any services provided to such person during the period such person was not eligible under the Subscriber's coverage.

Nondiscrimination

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

Effective Date of Coverage

You are eligible to be covered under this Certificate when it first became effective, January 1, 2020 or if you are a new employee of the Group, as determined by your employer.

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

Statements and Forms

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

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

Delivery of Documents

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

Contestability

Your policy shall not be contested except for nonpayment of premium, after it has been in force for two (2) years from its date of issue; and no statement made by a person shall be used in contesting the validity of the insurance unless it is contained in a written instrument signed by the person making such statement.

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 dissolution, or legal separation	Former spouse and any Dependent children who lose coverage	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Death of Subscriber	Surviving spouse and Dependent children	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.

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

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

1. Choosing Continuation

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

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

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

2. Second qualifying event

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

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

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

3. Terminating Continuation of Coverage - COBRA

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

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

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

DENTAL PROVIDERS AND CLAIMS PAYMENT

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

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

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

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

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

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

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

PROVIDER NETWORK STATUS

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

Participating Dentists

A Participating Dentist is a Dentist who has signed a written provider service agreement agreeing to service the program identified in this Certificate. For Covered Services performed by a Participating Dentist, the Maximum Allowed Amount is based upon the lesser of the Dentist's actual charges or the Schedule of Maximum Allowable Charges. Because Participating Dentists have agreed to accept the Maximum Allowed Amount as payment in full for services, they should not send you a bill or collect for amounts above the agreed upon Maximum Allowed Amount. However, you may receive a bill or be asked to pay a portion of the Maximum Allowed Amount to the extent you have exhausted your coverage for the service, have not met your Deductible, have a Coinsurance, have received non-covered services, or have exceeded the dental benefit maximum as outlined in the Summary of Benefits. Please call Our Customer Service Department at (844) 729-1565 for help in finding a Participating Dentist or visit Our website at www.anthem.com.

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 (844) 729-1565 for help in finding a Participating Dentist or visit Our website at www.anthem.com.

Customer Service is also available to assist you in determining 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 Member Services 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 188
Minneapolis, MN 55440-0188
(844) 729-1565

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

Dental Utilization Review

Dental utilization review is designed to promote the delivery of cost-effective dental care by encouraging the use of clinically recognized and proven procedures. It is included in your Plan to encourage you and your dentist to utilize your dental benefits in a cost-effective and clinically appropriate and recognized manner. Your right to benefits for Covered Services provided under this Plan is subject to review by licensed dentists who will apply certain policies, guidelines and limitations, including, but not limited to, our coverage/clinical guidelines, dental policy and utilization review features.

Dental utilization review is accomplished through pre-treatment review and retrospective review. Our dental coverage guidelines for pre-treatment review and retrospective review are intended to reflect general standards of care for dental practice applying state-specific regulations where necessary. The purpose of dental coverage guidelines is to assist in the interpretation of medical or dental necessity. In order to be expenses or services covered under this Plan, such expenses and services must meet Anthem's Medical or Dental Necessity requirements.

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, ENDODONTIC, PERIODONTAL, ORAL SURGERY, 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, COPAYS 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, endodontics, periodontal, oral surgery, prosthetic services 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, Copays 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 in a dental office or via telemedicine and when necessary and customary as determined by the standards of generally accepted dental practice. Telemedicine is the delivery of covered services from a dentist to a member through the use of interactive audio, video or other electronic media, not including standard telephone, facsimile or electronic mail.

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 or medically 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 or medically 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 or medically 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 or medically 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.

Retrospective Review

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

We provide a toll-free telephone number available during normal business hours to assist you or your Provider in obtaining information with respect to our utilization review process. This same number may be utilized after business hours to leave a message which will be responded to within two business days in non-emergent situations. This telephone number is listed on your identification card.

If you disagree with a utilization review decision and wish to file an appeal or appeal a decision previously made, you will find details on how to do this in the claim and appeal procedures section of this certificate. You may also contact customer service at the toll-free number on your identification card.

The utilization review process is governed by laws and regulations and may be modified from time to time by us as those laws and regulations may require.

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)

Periodic, Comprehensive and Periodontal Oral Evaluations - Any type of evaluation (checkup or exam) is covered 2 times per 12-month period.

NOTE: Comprehensive oral evaluations will be benefited 1 time per dental office, subject to the 2 times per 12-month period 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 12-month period limitation.

Limited, Detailed/Extensive and Problem Focused Evaluations - Covered 2 times per 12-month period.

Radiographs (X-rays)

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

Dental Cleaning

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

LIMITATION: Any combination of this procedure, Periodontal Maintenance, Scaling in the Presence of Moderate or Severe Gingival Inflammation or Full Mouth Debridement (see Periodontal Services section for the frequency of these services) is covered 2 times per 12-month period.

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 and fluoride varnish – Covered 1 time per 12-month period for Dependent children through the age of 14.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered 1 time per 60-month period for permanent first and second molars of eligible Dependent children through the age of 14.

Space Maintainers - Covered 1 time per lifetime on eligible Dependent children through the age of 18 for extracted primary posterior (back) teeth.

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

EXCLUSIONS - Coverage is NOT provided for:

1. Oral hygiene instructions, including guidance regarding home care. Some examples of oral hygiene instructions includes instructions or guidance on tooth brushing technique, flossing, and/or use of special oral hygiene aids.
2. Amalgam or composite restorations placed for preventive purposes.

Basic Restorative Services

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

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

Composite (white) Resin Restorations

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

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

Basic Extractions

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

Brush Biopsy

Consultations - Covered 1 time per 12 month period.

Pin Retention - Covered 1 time per 84-month period.

EXCLUSIONS - Coverage is NOT provided for:

1. Case presentation of detailed treatment plans and office visits, during and after regularly scheduled hours, when no other services are performed.
2. Athletic mouthguard, enamel microabrasion, and odontoplasty.
3. Tooth whitening agents and tooth bonding.
4. Placement or removal of sedative filling, base or liner used under a restoration.
5. Pulp vitality tests.
6. Diagnostic casts.
7. Secondary diagnostic tests in addition to the primary therapy.
8. Amalgam or composite restorations placed for preventive purposes.

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

Enhanced benefit for Members. Enhanced dental benefits are available for any member diagnosed with the following conditions:

- Cancer with chemotherapy
- Head and neck cancer with chemotherapy and/or radiation
- Solid organ transplant
- Heart disease
- Diabetes
- Pregnancy
- Stroke
- Kidney failure/dialysis
- Suppressed Immune System (HIV)

A member who is pregnant or diagnosed with gestational diabetes is eligible for the additional benefits for a maximum of two Coverage Years. A member diagnosed with the other conditions, are eligible for the additional benefits each Coverage Year until their coverage with the Plan terminates.

To obtain the additional benefit(s), the Member must complete the enhanced benefit application enrollment form and submit it to Us at P.O. Box 9062, Oxnard, CA 93036. The enhanced benefit(s) will be available on the first of the month following the date We receive the enhanced benefit enrollment form.

The following grid identifies and explains how your enhanced benefits will be administered:

Anthem Whole Health Connection								
	Periodontal Maintenance ¹	Periodontal Scaling and Root planing ²	Periodontal & Oral Evaluations ³	Routine Cleaning ⁴	Palliative Treatment ⁵	Fluoride ⁶	Sealants ⁷	Full Mouth Debridement ⁸
Diabetes	√	√	√	√	√			√
Heart Disease	√	√	√	√	√			√
Pregnancy	√	√	√	√	√	√	√	√
Stroke	√	√	√	√	√			√
Kidney Failure/Dialysis	√	√	√	√	√	√	√	√
Head and Neck Cancer w/ Chemo/ Radiation	√	√	√	√	√	√	√	√
Cancers (with chemo)	√	√	√	√	√	√	√	√
Solid Organ Transplant	√	√	√	√	√	√	√	√
Suppressed Immune System (HIV)	√	√	√	√	√			√
¹ Covered at standard frequency				² One additional scaling & root planing procedure per quadrant				
³ One additional oral evaluation				⁴ One additional routine cleaning; frequency shared with periodontal maintenance				
⁵ Covered at standard frequency				⁶ Removes age limits and provides one additional fluoride treatment				
⁷ Removes age limits				⁸ Covered at standard frequency				
Plan provides 100% coverage for qualified benefits and additional frequencies noted regardless of annual maximum/deductible in conjunction with qualified medical conditions.								

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
- Heart disease
- Diabetes
- Pregnancy
- Stroke
- Kidney failure/dialysis
- Suppressed Immune System (HIV)

The following grid identifies and explains how your enhanced benefits will be administered:

Anthem Whole Health Connection								
	Periodontal Maintenance ¹	Periodontal Scaling and Root planing ²	Periodontal & Oral Evaluations ³	Routine Cleaning ⁴	Palliative Treatment ⁵	Fluoride ⁶	Sealants ⁷	Full Mouth Debridement ⁸
Diabetes	√	√	√	√	√			√
Heart Disease	√	√	√	√	√			√
Pregnancy	√	√	√	√	√	√	√	√
Stroke	√	√	√	√	√			√
Kidney Failure/Dialysis	√	√	√	√	√	√	√	√
Head and Neck Cancer w/ Chemo/ Radiation	√	√	√	√	√	√	√	√
Cancers (with chemo)	√	√	√	√	√	√	√	√
Solid Organ Transplant	√	√	√	√	√	√	√	√
Suppressed Immune System (HIV)	√	√	√	√	√			√
¹ Covered at standard frequency				² One additional scaling & root planing procedure per quadrant				
³ One additional oral evaluation				⁴ One additional routine cleaning; frequency shared with periodontal maintenance				
⁵ Covered at standard frequency				⁶ Removes age limits and provides one additional fluoride treatment				
⁷ Removes age limits				⁸ Covered at standard frequency				
Plan provides 100% coverage for qualified benefits and additional frequencies noted regardless of annual maximum/deductible in conjunction with qualified medical conditions.								

EXCLUSIONS

This section indicates items which are excluded and are not considered Covered Services. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services.

Coverage is NOT provided for:

- a) Dental Services that have been paid under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. Benefits under this Certificate will not be reduced or denied because Dental Services are rendered to a Subscriber or Dependent who is eligible for or receiving Medical Assistance.
- b) Dental Services or health care services not specifically listed in the Covered Services section of this Certificate (including any hospital charges, prescription drug charges and Dental Services or supplies that do not have an American Dental Association Dental Procedure Code).
- c) Services provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist.
- d) Dental Services completed prior to the date the Member became eligible for coverage.
- e) Services of anesthesiologists.
- f) 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.
- g) 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.
- h) Dental Services performed other than by a licensed Dentist, licensed physician, his or her employees.
- i) 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.
- j) Tooth whitening agents and tooth bonding.
- k) Orthodontic treatment services, unless specified in this Certificate as a covered Dental Service benefit.
- l) Case presentations of detailed treatment plans, office visits during and after regularly scheduled hours, when no other services are performed.
- m) A permanent appliance or restoration (such as a partial, denture, bridge or crown) that has not been permanently cemented.
- n) Athletic mouth guards, enamel microabrasion and odontoplasty.
- o) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the Certificate.
- p) Bacteriologic tests.
- q) Separate services billed when they are an inherent component of a Dental Service.
- r) Interim or temporary removable or fixed prosthetic appliances (dentures, partials or bridges).
- s) Services for the replacement of an existing partial denture with a bridge.

- t) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- u) Provisional splinting, temporary procedures or interim stabilization.
- v) Placement or removal of sedative filling, base or liner used under a restoration.
- w) Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
- x) Oral hygiene instruction, including guidance regarding home care. Some examples of oral hygiene instructions includes instructions or guidance on tooth brushing technique, flossing, and/or use of special oral hygiene aids.
- y) Any charges which exceed the Maximum Allowed Amount.
- z) Pulp vitality tests
- aa) Secondary diagnostic tests in addition to the primary therapy.
- bb) Diagnostic casts
- cc) Incomplete root canals
- dd) Anatomical crown exposure.
- ee) Temporary anchorage devices.
- ff) Amalgam or composite restorations placed for preventive or cosmetic purposes.
- gg) Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.
- hh) Endodontic Services.
- ii) Prosthodontic Services.
- jj) Oral Surgery Services.
- kk) Major Restorative Services.
- ll) Prosthodontic Services.

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, if more than one treatment plan would be considered for a dental condition, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Member.
- b) Reconstructive Surgery: benefits shall be provided for reconstructive surgery when such Dental Procedure is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part, or when such Dental Procedure is performed on a covered Dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, however that such services are dental reconstructive surgical services.
- c) Benefits for inpatient or outpatient expenses arising from Dental Services up to age 18, including orthodontic and oral surgery services, involved in the management of birth defects known as cleft lip and cleft palate. For programs without orthodontic coverage: Dental orthodontic services not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this dental benefit program. For programs with orthodontic coverage: If coverage for the treatment of cleft

lip or cleft palate is available under any other policy or contract of insurance, this Certificate shall be primary and the other policy or contract shall be secondary.

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

Optional Treatment Plans

In all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Member and the Dentist; however, if more than one treatment plan would be considered for a dental condition, 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 contact Anthem at the following address and telephone number: PO Box 1171 Minneapolis, MN 55440-1171 and (844) 729-1565.

Form or Content of Certificate

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

Relationship of Parties (Plan - Participating Dentists)

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

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

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

Not Liable for Provider Acts or Omissions

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

Identification Card

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

Circumstances Beyond the Control of the Plan

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

Participating Dentists shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Employer Premiums

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

Extension of Benefits

If this Dental Certificate terminates, benefits will be continued for a period of 60 days for the following:

1. The installation of new appliances and modifications to appliances for which a master impression was made prior to the benefit termination date.
2. An installation of a crown, bridge, or cast restoration for which the tooth was prepared prior to the benefit termination date.

Extension of Benefits will not apply if the group policy terminates.

Coordination of Benefits

Special COB rules apply when you or members of your family have additional dental care coverage through other group dental plans, including:

- group insurance plans, including other Anthem plans;
- labor management trustee plans, union welfare plans, employer welfare plans, employer organization plans, or employee benefit organization plans; and
- coverage under any tax-supported or government program to the extent permitted by law.

All benefits provided under this agreement are subject to this provision. However, benefits will not be increased by this COB provision. This provision applies if the total payment under this agreement absent this provision and under any other contract is greater than the value of covered services.

Primary coverage and secondary coverage. When a member is also enrolled in another group dental plan, one coverage will pay benefits first (be primary) and the other will pay second (be secondary). The primary coverage will pay benefits first. The decision of which coverage will be primary or secondary is made using benefit determination rules.

When we provide secondary coverage, we first calculate the amount that would have been payable had we been primary. Then we coordinate benefits so that the combination of the primary plan's payment and our payment does not exceed the amount we would have paid had it been primary.

Definition of "other contract". Other contract means any arrangement providing dental care benefits or services through:

- group or blanket insurance coverage;
- group Anthem, health maintenance organization, and other prepayment coverage;
- coverage under labor management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans; and
- coverage under any tax supported or government program to the extent permitted by law.

If there is more than one other contract, this provision will apply separately to each. If another contract has a coordination of benefits provision that applies to only part of its services, the terms of this paragraph

will be applied separately to that part and to any other part.

Anthem will not determine the existence of any other contract, or the amount of benefits payable under any other contract except this agreement. The payment of benefits under this agreement shall be affected by the benefits payable under other contracts only when Anthem is given information about other contracts.

If the rules of this agreement and the other contract both provide that this agreement is primary, then this agreement is primary. When Anthem determines that this agreement is secondary under the rules described below, benefits will be coordinated so that our payment plus the other contract's payment will not exceed Anthem *maximum allowed amount* for covered services.

Order of Benefit Determination Rules

1. Pediatric Dental Coordination of Benefits (COB). If pediatric dental Essential Health Benefits are included as part of the medical plan, the medical plan will be the primary coverage and any standalone dental plan will be secondary.
2. If you have two dental plans, the plan which includes pediatric dental Essential Health Benefits will be the primary coverage.
3. If neither of the above applies, the Order of Benefit Determination Rules below will determine coordination of benefits.
4. If you are covered under one plan as a primary insured and another plan as a dependent, the plan under which you are the primary insured will be the primary coverage.
5. As required by law, if you or a dependent also has coverage under Medicare, this plan will always be primary.
6. For children who are covered under both parents' contracts, the following will apply:
 - a. The contract of the parent whose birthday occurs earlier in the calendar year will be primary.
 - b. When parents are separated or divorced, the following special rules will apply:
 - i. If the parent with custody has not remarried, that parent's contract will be primary.
 - ii. If the parent with custody has remarried, that parent's contract will be primary and the stepparent's contract will be secondary. The benefits of the contract of the parent without custody will be determined last.
 - iii. The rules listed above may be changed by a court decree:
 - A court decree that orders one of the parents to be responsible for health care expenses will cause that parent's contract to be primary, but only if the entity providing the benefits in this case is notified of the court decree before applying benefits.
 - If the court decree does not state that one of the parents is responsible for health care expenses and both parents have joint custody, the contract of the parent whose birthday occurs earlier in the calendar year will be primary.
7. If the other contract includes the gender rule, then that rule will be used instead of the rules listed above. The gender rule states that the father's contract will be primary for the children.
8. If there are situations not covered above, then the contract that has been in effect the longest period of time (without interruption) will be primary. There is an exception to this rule. The contract that covers a working employee (or his dependent) will be primary. The contract of a laid-off employee, a retired employee, or a person on continuation of coverage options under federal or state law will be secondary.
9. If another contract has different rules from those listed above other than the gender rule, that contract will be primary.

If payments should have been made under this agreement under the rules of this provision, but they have been made under any other contract, Anthem may pay an entity (provider, other carrier, etc.) that has paid any amounts it determines will meet the intent of this provision. These amounts shall be deemed to be benefits paid under this agreement. Upon this payment, Anthem will no longer be liable

under this agreement.

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 Summary 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 Member Services. You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

Get help in your language

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

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

Spanish

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

Arabic

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

Burmese

ဤအချက်အလက်များနှင့် အကူအညီကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရရှိခွင့် သင့်တွင်ရှိပါသည်။ အကူအညီ ရယူရန် သင့် ID ကဒ်ပေါ်ရှိ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန၏ နံပါတ်သို့ ခေါ်ဆိုပါ။ (TTY/TDD: 711)

Chinese

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

Dutch

U hebt het recht om deze informatie en hulp gratis in uw taal te krijgen. Bel het ledendienstnummer op uw ID-kaart voor ondersteuning. (TTY/TDD: 711)

French

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

German

Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Hindi

आपके पास यह जानकारी और मदद अपनी भाषा में मुफ्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Japanese

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

Korean

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

Pennsylvania Dutch

Du hoscht die Recht selle Information un Hilfe in dei Schprooch mitaus Koscht griege. Ruf die Member Services Nummer uff dei ID Kaarte fer Hilfe aa. (TTY/TDD: 711)

Punjabi

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

Russian

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

Tagalog

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

Vietnamese

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

It's important we treat you fairly

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

ANTHEM DENTAL

FOR CLAIMS AND ELIGIBILITY

Anthem Dental Claims
PO Box 188
Minneapolis, Minnesota 55440-0188
(844) 729-1565

FOR APPEALS

P.O. Box 1122
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