THE AEROSPACE CORPORATION

January 1, 2021

Dental Net ®

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

Anthem Blue Cross
21215 Burbank Blvd.
Woodland Hills, California 91367

This Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form is a summary of the important terms of your health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage. Your employer will provide you with a copy of the health plan contract upon request.

TABLE OF CONTENTS

YOUR DENTAL BENEFITS

BASIC FACTS

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS DENTAL CARE MAY BE OBTAINED.

We agree to furnish to you the *plan* of dental benefits explained in this Evidence of Coverage Form and any amendments thereto, subject to the terms and conditions of the *agreement* issued to the *group*. These benefits are available to you provided that services are rendered or authorized by your *participating dentist*, your *participating dental office* or us.

WHAT IS DENTAL NET?

Dental Net is a statewide dental program. The program consists of a network of *participating dental offices* and dental professionals who have contracted with us to provide you with the wide range of dental services for which you are covered under this *plan*. From these many providers, you choose the *participating dental office* that will provide your dental care.

YOUR ID CARD

Your key to Dental Net is your identification card. Be sure to keep this card with you and to present it whenever you are requested to do so.

CHOOSING A DENTAL OFFICE AND DENTIST

Upon enrollment, each *member* is asked to choose a Dental Net *participating dental office*. Each *member* is allowed to choose his/her own *participating dentist*. Your *participating dentist* will diagnose and treat most of your dental conditions and will coordinate all your dental care – referring you to specialists when necessary. We urge you to develop a close relationship with your *participating dentist* and to follow his or her advice carefully.

CHANGING PARTICIPATING DENTAL OFFICES

Requests by the Member. You may transfer from one *participating dental office* to another. To do this, you must call us toll free at 1-800-627-0004, or write us, by the 15th of the month.

Request by the Participating Dental Office. If a *participating dental office* requests a *member's* enrollment to be transferred, it will be considered based upon the nature of the request. If the request is due to a *member's* abusive language, behavior or lack of cooperation displayed in the dental office, we may notify the *group* of the incident and request the *member's* Dental Net coverage to be terminated from the *group's agreement* with us, as indicated under the section WHO'S COVERED AND WHEN: WHEN YOUR COVERAGE ENDS.

HOW TO OBTAIN CARE

The procedures you follow to obtain care depend on the type of care you need: General Care, Specialty Referral Care or Emergency Care. In reading over these procedures below, you will notice one important rule: we (your *participating dentist,* your *participating dental office* and us) are responsible for authorizing all the care you receive. If we do not authorize your care, benefits will not be payable under this *plan*. If you are ever in doubt, contact your *participating dental office* or us.

GENERAL CARE

Your participating dentist is the first person you should consult for dental care. He or she is responsible for providing you with dental care and determining when you need Specialty Referral Care.

To make an appointment with *your participating dentist*, call *your participating dental office*. (Please call in advance, especially if specific days or times are desired.) When you call, please **identify yourself as a Dental Net *member*** and have the following information from your identification card available:

- Your name
- The certificate number on your ID card
- The *group* number from your ID card
- The name of *your participating dentist* (If you have not selected a *dentist*, call us toll free at 1-800-627-0004.)
- A brief explanation of your symptoms, if any

Your participating dental office will then schedule an appointment for you or otherwise arrange for appropriate care.

When you come in for your appointment, you will be asked to show your identification card. Since you must have this card to receive your Dental Net benefits, be sure to have it with you.

Upon your first visit to *your participating dental office*, it is most common to expect an examination, x-rays and treatment evaluation only. Subsequent appointments for follow-up treatment are scheduled based upon this evaluation and those procedures requiring more immediate attention.

If you need to cancel or reschedule an appointment, please notify *your participating dental office* as far in advance as possible. This courtesy may allow *your participating dental office* to accommodate another person in need of dental treatment. ***Your participating dental office*** **may charge for a broken appointment or failure to cancel if you have not provided at least 24 hours notice.** These charges are your responsibility and are NOT reimbursable by us.

Second Opinions. If you have a question about your dental condition or about a plan of treatment recommended by your *participating dentist* or a *participating specialist* to whom you were referred, you may receive a second dental opinion at no charge to you. You must request a second opinion through the Dental Net Member Services Department. The second opinion will consist of a consultation only. No other services or procedures are included. When you request a second dental opinion you will receive a decision promptly. If you have a serious dental condition, a decision will be made within 72 hours whenever possible. If your request is approved, the second opinion will be provided by another *dentist* or *specialist* of your choice who contracts with Dental Net. If your request is denied, you may appeal the denial through our grievance procedures (see GRIEVANCE PROCEDURES). Your grievance will be reviewed by a *dentist* with an appropriate clinical background.

SPECIALTY REFERRAL CARE

Your participating dental office is responsible for providing all *covered services,* subject to any applicable *member co-payments*, as listed in the sections WHAT'S COVERED and SCHEDULE OF CO-PAYMENTS. However, certain dental services may be eligible for referral to a *participating specialist*. If *your participating dentist* determines that specialty care may be needed, he or she will submit a request for authorization for specialty referral to us.

If the request is authorized, we will send notification to you indicating the following:

- The services that have been authorized
- The *participating specialty office* that will provide care
- The time limitation that you have to receive the services authorized
- Any *co-payments* you will be required to pay that may apply to the services

Referrals for specialty care are made at the sole and absolute discretion of your *participating dental office* and us. Additionally, the *participating specialty office* designated to provide specialty referral care is chosen at our sole and absolute discretion.

When you receive the authorization, you should contact the *participating specialty office* to arrange for an appointment. The specialty office will schedule a consultation appointment.

After the evaluation and consultation of the services to be performed, the specialty office will schedule your next appointment to begin the authorized *specialty referral services*. In the event there are any changes to the authorized *specialty referral services* suggested by the *participating specialty office*, there may be a delay while we review the proposed changes for medical/dental necessity.

If the request is not authorized because it does not meet the specialty referral guidelines, you will be notified by us.

You should not be billed by the *participating specialist* for authorized *specialty referral services*. However, you are responsible for all applicable *co-payments* which are to be paid to the *participating specialist* at the time the services are provided.

REMEMBER: ONLY THE SERVICES WHICH ARE REFERRED BY YOUR PARTICIPATING DENTAL OFFICE AND AUTHORIZED BY US ARE TO BE PROVIDED BY THE REFERRAL SPECIALIST. ANY SERVICES WHICH ARE PROVIDED WITHOUT REFERRAL FROM YOUR PARTICIPATING DENTAL OFFICE AND AUTHORIZATION BY US WILL NOT BE COVERED UNDER THIS PLAN AND WILL BE YOUR FINANCIAL RESPONSIBILITY.

EMERGENCY CARE

Emergency services are dental services provided for the initial treatment for alleviation of severe pain or bleeding and/or swelling. *Emergency services* are not for continuing any treatment plan currently in process, unless it has been authorized. While it is intended that all services, including *emergency services*, are to be provided by *your participating dental office*, *we* recognize that special circumstances may exist which prevent *you* from receiving emergency dental treatment from *your participating dental office*. This *plan* provides benefits for two different types of *emergency services* situations which are described below. You are responsible for any applicable *co-payments* regardless of who provided the *emergency services*.

Outside the Enrollment Area. If you are **temporarily** more than 35 miles from *your participating dental office* and you need emergency dental care, you may obtain care from any *dentist*. You will have to pay for such *emergency services*; however, upon submission of an itemized paid receipt of the *emergency services* rendered, we will reimburse you up to a maximum of **$50**, less any applicable *co-payments* for the procedures performed. If you present an itemized statement from a *dental office* which is located within 35 miles of *your participating dental office*, you will NOT be reimbursed for that expense.

Within the Enrollment Area. If you are within the *enrollment area* of *your participating dental office*, you must obtain care from that office.

WHAT'S COVERED

The wide range of dental benefits available to you under this *plan* are listed in detail in the SCHEDULE OF CO-PAYMENTS. What follows is a brief description of how the benefits of this *plan* work.

COORDINATION OF BENEFITS

The benefits of this *plan* are subject to coordination of benefits under certain other plans. For a detailed explanation, please see the section titled COORDINATION OF BENEFITS**.**

CO-PAYMENTS

Some services are provided to you free of *co-payments*. For certain other services, you are required to pay a *co-payment* amount at the time the services are provided. These *co-payments* are specified in the SCHEDULE OF CO-PAYMENTS.

TYPES OF SERVICE

The following is a brief overview of the dental services available to you under this *plan*. For a more detailed listing, refer to the SCHEDULE OF CO-PAYMENTS.

Diagnostic. Diagnostic services are routine services to determine the type of treatment you may need.

Preventive. Preventive services are performed to help prevent certain conditions from occurring.

Restorative. Restorative services are performed to restore tooth structure lost as a result of dental decay.

Endodontics. Endodontic services are performed to treat diseases of the tooth pulp nerve and associated structures.

Periodontics. Periodontic services are performed to treat diseases of the gums and supporting structures.

Removable Prosthodontics. Removable prosthodontic services are performed to replace missing teeth with full or partial dentures.

Fixed Prosthodontics. Fixed prosthodontic services are performed to repair tooth structure lost due to dental decay or replace missing teeth with bridges.

Oral Surgery. Oral surgery is performed when you require surgical procedures involving the teeth, bone and gums associated with the teeth.

WHEN DENTAL PROCEDURES START

A dental procedure is considered started when the actual performance of the procedure starts, except that:

- For fixed bridgework and full or partial dentures, it starts when the first impressions are taken and/or abutment teeth are prepared; or
- For crowns, inlay or onlay, it starts on the first date of preparation of the tooth involved; or
- For root canal therapy, it starts when the pulp chamber of the tooth is opened.

WHAT'S NOT COVERED AND LIMITED SERVICES

The services provided under this *plan* are all subject to the exclusions and limitations listed below. (The titles given to the exclusions and limitations are for ease of reference; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

Important: If you decide to receive dental services that are not covered under this *plan*, a *participating dentist* may charge you his or her usual and customary rate for those services. Prior to providing you with dental services that are not a covered benefit, the *dentist* should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about the dental services that are covered under this *plan*, please call us at the member services telephone number listed on your ID card. To fully understand your coverage under this *plan*, please carefully review this Evidence of Coverage document.

LIMITED SERVICES

Denture Relines. Complete and/or partial denture relines or rebases are limited to one per denture during any 12-month period.

Impactions. Removal of impacted teeth is limited to impactions which show radiographic evidence of a pathologic condition or for which the *member* experiences unresolved symptoms of infection, swelling or chronic pain.

Pediatric Annual Maximum. Pediatric dental services are limited to **$500** per calendar *year* for each *child*. Referral to a pedodontist will be considered for children to the age of 5. Charges in excess of **$500** will be your financial responsibility.

Periodontal Procedures. Periodontal scaling and root planing and/or gingival curettage are limited to one course of therapy per quadrant during any 12-month period.

Precious Metals. The use of alloys with 25% or more noble metal content for any restorative procedure is considered optional and, if used, the additional cost for such alloy will be your responsibility.

Professionally Acceptable Treatment. In cases where multiple acceptable methods of treatment exist, the least expensive professionally acceptable treatment is considered the covered benefit.

Prophylaxis. Prophylaxis procedures are limited to two treatments per *calendar year*.

Prosthodontic Replacements:

1. Partial dentures are not eligible for replacement within five years of original placement unless required as a result of additional tooth loss that cannot be restored by modification of the existing partial denture.

2. Crowns, bridges, inlays and/or complete dentures are not eligible for replacement within five years of original placement.

Oral Exams. Oral exams are limited to two per *calendar year*.

Unauthorized Services. Dental services must be received from your *participating dental office* unless an exception is specifically authorized in writing by your *participating dental office* or by us.

SERVICES NOT COVERED

Acts of Third Parties. Under some circumstances, a *member* may need services under this *plan* for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation on the part of such third party for an injury, disease or other condition. In that event, any benefits we pay under this *plan* for such covered services will be subject to the following:

1. We and *your participating dental office* will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise, that you receive from the third party, the third party's insurer, or the third party's guarantor. The lien will be in an amount equal to the reasonable cash value of the benefits provided by *your participating dental office* and us under this *plan* for the treatment of the illness, disease, injury or condition for which the third party is liable, but, not more than the amount allowed by California Civil Code Section 3040.

2. You must advise *your participating dental office* and us in writing within 60 days of filing a claim against the third party, and take necessary action, furnish such information and assistance, and execute such papers as *your participating dental office* and we may require to facilitate enforcement of our rights. You must not take action which may prejudice the rights or interest of *your participating dental office* and us under this *plan*. Failure to give such notice to, or cooperate with, *your participating dental office* and us, or actions that prejudice the rights or interests of *your participating dental office* and us will be a material breach of this *plan* and will result in your being personally responsible for reimbursing *your participating dental office* and us.

3. We or your *participating dental office* will be entitled to collect on our lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.

Composite Resin and Porcelain Restorations. Porcelain or composite labial veneers for fixed prosthodontics, posterior to the 2nd bicuspid and composite fillings posterior to the cuspid. Any material other than base metal is optional and will be an additional cost to the *member*.

Congenital (Hereditary) or Developmental Malformations. Dental treatment or expenses incurred in connection with the correction of congenital or developmental malformations including but not limited to enamel hypoplasia, fluorosis, anodontia, supernumerary or impacted teeth other than third molars.

Cosmetic Services. Dental services necessary solely for cosmetic reasons including, but not limited to, bleaching of non-vital discolored teeth, veneers and all other cosmetic procedures (unless specifically shown as a covered benefit).

Cysts and Neoplasms. Histopathological exams, and/or the removal of tumors, cysts, neoplasms, and foreign bodies.

Experimental or Investigative Procedures. Procedures which are considered experimental or investigative or which are not widely accepted as proven and effective procedures within the organized dental community.

Extensive Oral Rehabilitation. Dental treatment or procedures requiring or associated with fixed prosthodontic restorations when part of extensive oral rehabilitation or reconstruction. (Other than for replacement of structure lost due to dental decay). Five (5) or more crowns subject to our approval.

Fractures or Dislocations. Treatment of jaw fractures or dislocations.

General Anesthesia. General anesthesia, inhalation sedation, intravenous sedation or intramuscular sedation.

Government Programs. Care or treatment which is obtained from, or for which payment is made by, any Federal, State, County, Municipal, or other government agency, including any foreign government.

Hospital Charges. Hospital and associated physician charges of any kind or charges for any dental treatment which cannot be performed in the *participating dental office*.

Implants. Dental procedures and charges incurred as part of implants or the removal of the same. Fixed or removable prosthetics in conjunction with implants. Prophylaxis on implants.

Lost or Stolen Dentures or Appliances. Replacement of lost crowns, lost or stolen dentures, bridgework, or other dental appliances.

Member Health Limitations. Charges for any dental treatment, which because of your general health, or mental, emotional, behavioral, or physical limitations, cannot be performed in the *participating dental office*.

Not Medically Necessary. A dental treatment plan which in our opinion, or the opinion of the *participating dentist*, is not *medically necessary* or will not produce beneficial results.

Periodontal Splinting. Dental treatment or expenses incurred in connection with periodontal splinting.

Procedures Not Specified as Covered. Any procedure not specifically listed as a *covered service*.

Prosthetic Services Age Limitations. Inlays, onlays, crowns, fixed bridges or removable cast partials for *members* under sixteen (16) years of age. Space maintainers for *members* over age sixteen (16).

Services Provided Before or After the Term of Your Coverage. Dental treatment or expenses incurred in connection with any dental procedure started prior to your *effective date* or after termination of your coverage, except as specifically stated under EXTENSION OF BENEFITS.

Surgical Services. Tooth implantation or transplantation, orthognathic surgery, soft tissue or osseous grafts, hemisection, or root amputation, apexification, alveoloplasty, vestibuloplasty, or ostectomy procedures.

Treatment by a Non-Participating Dentist. Any corrective treatment required as a result of dental services performed by a *non-participating dentist* while this coverage is in effect, and any dental services started by a *non-participating dentist*, will not be our responsibility, nor the responsibility of the *participating dental office*, for completion.

Treatment of the Joint of the Jaw. Diagnosis or treatment by any method of any condition related to the jaw joint (temporomandibular joint) or associated musculature, nerves and other tissues.

Vertical Dimension and Attrition. Dental treatment or procedures (other than those for replacement of structure lost due to dental decay) required in conjunction with opening a bite or replacing tooth structure lost by wear, erosion or abrasion, but not limited to bruxism. (Does not apply to alteration by removable prothodontics.)

Workers' Compensation. Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, under any workers' compensation or occupational disease law, even if you did not claim those benefits.

If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, benefits will be provided subject to our right of recovery and reimbursement under California Labor Code Section 4903, and as described in the "Acts of Third Parties" provision set forth in this section.

Drugs or Dispensing of Drugs. Plan does not cover prescription drugs as a dental benefit.

Questionable, Guarded or Poor Prognosis. Teeth with questionable, guarded or poor prognosis are not covered for endodontic treatment, periodontal surgery or crown and bridge. We will allow for observation or extraction and prosthetic replacement.

Personalization, Characterization or Precision Attachments. Precision attachments, characterization or personalization of dentures is excluded.

Crown Lengthening. Crown exposure, ligation and crown lengthening are not covered.

Removal of Third Molars. Immature erupting third molars are not covered for extraction, i.e., tooth proceeding through a normal eruption process.

Primary Restorations. Gold, porcelain or resin fillings on primary teeth are excluded.

Build Ups. Amalgam, composite or cement build-ups are not a separate benefit, but are considered part of the completed restoration.

Denture Replacement. Dentures, full or partial-replacements will be made only if existing denture is at least five (5) years old, is unsatisfactory and cannot be made serviceable.

WHO'S COVERED AND WHEN

HOW YOU ENROLL

ELIGIBLE STATUS

1. **Subscribers.** You are eligible to enroll as a *subscriber* under this *plan* as determined by the *group*. Please contact your Human Resources office for more information.

2. **Family Members.** The following are eligible to enroll as *family members*: (a) Either the *subscriber's spouse* or *domestic partner;* and (b) A *child*.

Definition of Family Member

1. **Spouse** is the *subscriber's* spouse as recognized under state or federal law. This includes same sex spouses when legally married in a state that recognizes same-sex marriages. Spouse does not include any person who is: (a) covered as a *subscriber*; or (b) in active service in the armed forces.

2. **Domestic partner** is the *subscriber*'s domestic partner under a legally registered and valid domestic partnership. Domestic partner does not include any person who is: (a) covered as a *subscriber*; or (b) in active service in the armed forces.

   For a domestic partnership, other than one that is legally registered and valid, in order for the *subscriber* to include their domestic partner as a *family member*, the *subscriber* and domestic partner must meet the following requirements:

   a. Both persons have a common residence.

   b. Neither person is married to someone else nor a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.

   c. The two persons are not related by blood in a way that would prevent them from being married to each other in California, or if they reside in another state or commonwealth, that state or commonwealth;

   d. Both persons are at least 18 years of age.

e. Both persons are capable of consenting to the domestic partnership.

f. Both partners must provide the *group* with a signed, notarized, affidavit certifying they meet all of the requirements set forth in 2.a through 2.e above, inclusive.

As used above, "have a common residence" means that both domestic partners share the same residence. It is not necessary that the legal right to possess the common residence be in both of their names. Two people have a common residence even if one or both have additional residences. Domestic partners do not cease to have a common residence if one leaves the common residence but intends to return.

3. **Child** is the *subscriber's*, *spouse's* or *domestic partner's* natural child, stepchild, or legally adopted child, subject to the following:

   a. The child is under 26 years of age.

   b. The unmarried child is 26 years of age or older and: (i) is chiefly dependent on the *subscriber, spouse or domestic partner* for support and maintenance, and (ii) is incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the child is incapable of self-sustaining employment due to a physical or mental condition. We must receive the certification, at no expense to us, within 60-days of the date the *subscriber* receives our request. We may request proof of continuing dependency and that a physical or mental condition still exists, but not more often than once each year after the initial certification. This exception will last until the child is no longer chiefly dependent on the *subscriber, spouse* or *domestic partner* for support and maintenance due to a continuing physical or mental condition. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

   c. A child who is in the process of being adopted is considered a legally adopted child if we receive legal evidence of both: (i) the intent to adopt; and (ii) that the *subscriber*, *spouse* or *domestic partner* have either: (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption.

Legal evidence to control the health care of the child means a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or relinquishment form, signed by the child's birth parent, or other appropriate authority, or in the absence of a written document, other evidence of the *subscriber's*, the *spouse's* or *domestic partner's* right to control the health care of the child.

d. The term "child" does not include any child for whom the *subscriber*, *spouse* or *domestic partner* is the legal guardian, but who is not the *subscriber's*, *spouse's* or *domestic partner's* natural child, stepchild or adopted child.

ELIGIBILITY DATE

1. **For Subscribers:** You become eligible for coverage in accordance with rules established by your employer. For specific information about your employer's eligibility rules for coverage, please contact your Human Resources or Benefits Department.

2. **For Family Members:** You become eligible for coverage on the later of: (a) the date the *subscriber* becomes eligible for coverage; or (b) the date you meet the *family member* definition.

If, after you become covered under this *plan*, you cease to be eligible due to termination of employment, and you return to an eligible status within six months after the date your employment terminated, you will become eligible to re-enroll for coverage on the first day of the month following the date you return.

ENROLLMENT

To enroll as a *subscriber*, or to enroll *family members*, the *subscriber* must properly file an application. An application is considered properly filed, only if it is personally signed, dated, and given to the *group* within 31 days from your eligibility date. We must receive this application from the *group* within 90 days of the eligibility date. If any of these steps are not followed, your coverage may be denied.

EFFECTIVE DATE

Subject to the timely payment of subscription charges on your behalf, your coverage will begin as follows:

1. **Timely Enrollment.** If you enroll for coverage before, on, or within 31 days after your eligibility date, then your coverage will begin as follows: (a) for *subscribers*, on your eligibility date; and (b) for *family members*, on the later of (i) the date the ***subscriber's*** coverage begins, or (ii) the first day of the month after the *family member* becomes eligible. If you become eligible before the *agreement* takes effect, coverage begins on the effective date of the *agreement*.

2. **Late Enrollment.** If you fail to enroll within 31 days after your eligibility date, you must wait until the *group's* next Open Enrollment Period to enroll.

3. **Disenrollment.** If you voluntarily choose to disenroll from coverage under this *plan*, you must wait until the ***group's*** next Open Enrollment Period to enroll.

For late enrollees and disenrollees: You may enroll earlier than the ***group's*** next Open Enrollment Period if you meet any of the conditions listed under SPECIAL ENROLLMENT PERIODS.

Special Enrollment Periods

You may enroll without waiting for the ***group's*** next open enrollment period if you are otherwise eligible under any one of the circumstances set forth below:

1. You have met all of the following requirements:

    a. You were covered as an individual or dependent under either:

        i. Another employer group dental plan or dental insurance coverage, including coverage under a COBRA continuation; or

        ii. A state Medicaid plan or under a state child health insurance program (SCHIP), including the Healthy Families Program or Access for Infants and Mothers (AIM) Program.

    b. Your coverage under the other dental plan wherein you were covered as an individual or dependent ended as follows:

i. If the other dental plan was another employer group dental plan or dental insurance coverage, including coverage under a COBRA continuation, coverage ended because you lost eligibility under the other plan, your coverage under a COBRA continuation was exhausted, or employer contributions toward coverage under the other plan terminated. You must properly file an application with the *group* within 31 days after the date your coverage ends or the date employer contributions toward coverage under the other plan terminate.

   Loss of eligibility for coverage under an employer group dental plan or dental insurance includes loss of eligibility due to termination of employment or change in employment status, reduction in the number of hours worked, loss of dependent status under the terms of the *plan*, termination of the other plan, legal separation, divorce, death of the person through whom you were covered, and any loss of eligibility for coverage after a period of time that is measured by reference to any of the foregoing.

ii. If the other dental plan was a state Medicaid plan or a state child health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program, coverage ended because you lost eligibility under the program. You must properly file an application with the *group* within 60 days after the date your coverage ended.

2. A court has ordered coverage be provided for a *spouse, domestic partner* or dependent *child* under your employee dental plan and an application is filed within 31 days from the date the court order is issued.

3. You have a change in family status through either marriage or domestic partnership, or the birth, adoption, or placement for adoption of a *child*:

   a. If you are enrolling following marriage or domestic partnership, you and your new *spouse* or *domestic partner* must enroll within 31 days of the date of marriage or domestic partnership. Your new *spouse* or *domestic partner's* children may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above.

b. If you are enrolling following the birth, adoption, or placement for adoption of a *child*, your *spouse* (if you are already married) or *domestic partner*, who is eligible but not enrolled, may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Application must be made within 31 days of the birth or date of adoption or placement for adoption.

4. You are an employee who is a reservist as defined by state or federal law, who terminated coverage as a result of being ordered to military service as defined under state or federal law, and apply for reinstatement of coverage following reemployment with your employer. Your coverage will be reinstated without any waiting period. The coverage of any dependents whose coverage was also terminated will also be reinstated. For dependents, this applies only to dependents who were covered under the plan and whose coverage terminated when the employee's coverage terminated. Other dependents who were not covered may not enroll at this time unless they qualify under another of the circumstances listed above.

Effective date of coverage. For enrollments during a special enrollment period as described above, coverage will be effective on the first day of the month following the date you file the enrollment application, except as specified below:

1. If a court has ordered that coverage be provided for a dependent *child*, coverage will become effective for that *child* on the earlier of (a) the first day of the month following the date you file the enrollment application or (b) within 30 days after we receive a copy of the court order or of a request from the district attorney, either parent or the person having custody of the *child*, the employer, or the *group* administrator.

2. For enrollments following the birth, adoption, or placement for adoption of a *child*, coverage will be effective as of the date of birth, adoption, or placement for adoption.

3. For reservists and their dependents applying for reinstatement of coverage following reemployment with the employer, coverage will be effective as of the date of reemployment.

OPEN ENROLLMENT PERIOD

The *group* has an open enrollment period once each *year*. During that time, an individual who meets the eligibility requirements as a *subscriber* under this *plan* may enroll. A *subscriber* may also enroll any eligible *family members* at that time. Persons eligible to enroll as *family members* may enroll only under the *subscriber's plan*.

For anyone so enrolling, coverage under this *plan* will begin on the first day of the *plan year* following the end of the Open Enrollment Period. Coverage under the former plan ends when coverage under this *plan* begins.

WHEN YOUR COVERAGE ENDS

Your coverage under this *plan* may be canceled **without notice from us** for any of the reasons explained below. You are not entitled to the benefits of this *plan* for any services rendered after your coverage has been canceled, even if the services were part of a treatment plan begun before your coverage ended.

SERVICE RELATED EVENTS

We retain the right to cancel your coverage under this *plan* for any of the reasons listed below:

1. If you fail or refuse to make *co-payments* at the time the services are provided;
2. If you interfere with the normal operations of the dental office;
3. If you use threatening or aggressive behavior;
4. If you refuse to follow a prescribed course of treatment and the *dentist* believes that no professionally acceptable alternative exists. If you continue to refuse to follow the prescribed course of treatment, your coverage may be canceled.

NON-SERVICE RELATED EVENTS

Additionally, your coverage under this *plan* is subject to cancellation **without notice from us** for any of the reasons listed below. (We do not provide notice of cancellation to individuals but will notify the *group*.)

1. If the *agreement* terminates, your coverage ends at the same time. The *agreement* may be canceled or changed without notice to you.
2. If the *group* no longer provides coverage for the class of *members* to which you belong, your coverage ends on the effective date of that change. If the *agreement* is amended to delete coverage for *family members,* a *family member's* coverage ends on the effective date of that change.
3. Coverage for *family members* ends when *subscriber's* coverage ends.
4. Coverage ends at the end of the period for which subscription charges have been paid to us on your behalf when the required subscription charges for the next period are not paid.

5. If you voluntarily cancel coverage at any time, coverage ends on the subscription charge due date coinciding with or following the date of voluntary cancellation, as provided by written notice to us.

6. If you no longer meet the requirements set forth in the “Eligible Status” provision of HOW YOU ENROLL, your coverage ends as of the subscription charge due date coinciding with or following the date you cease to meet such requirements.

Exceptions to Item 6:

a. **Leave of Absence.** If you are a *subscriber* and the *group* pays subscription charges to us on your behalf, your coverage may continue for up to six months during a temporary leave of absence approved by the *group*. This time period may be extended if required by law.

b. **Handicapped Children:** If a *child* reaches the age limit shown in the "Eligible Status" provision of this section, the *child* will continue to qualify as a *family member* if he or she is (i) covered under this *plan,* (ii) chiefly dependent on the *subscriber*, *spouse* or *domestic partner* for support and maintenance*,* and (iii) incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the *child* has a physical or mental condition that makes the *child* incapable of obtaining self-sustaining employment. We will notify the *subscriber* that the *child's* coverage will end when the *child* reaches the *plan's* upper age limit at least 90-days prior to the date the *child* reaches that age. The *subscriber* must send proof of the *child's* physical or mental condition within 60-days of the date the *subscriber* receives our request. If we do not complete our determination of the *child's* continuing eligibility by the date the *child* reaches the *plan's* upper age limit, the *child* will remain covered pending our determination. When a period of two years has passed, we may request proof of continuing dependency due to a continuing physical or mental condition, but not more often than once each year. This exception will last until the *child* is no longer chiefly dependent on the *subscriber*, *spouse* or *domestic partner* for support and maintenance or a physical or mental condition no longer exists. A *child* is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

Note: If a marriage or domestic partnership terminates, the *subscriber* must give or send to the *group* written notice of the termination. Coverage for a former *spouse* or *domestic partners*, and their dependent *children*, if any, ends according to the "Eligible Status" provisions. If Anthem suffers a loss because of the *subscriber* failing to notify the *group* of the termination of their marriage or domestic partnership, Anthem may seek recovery from the *subscriber* for any actual loss resulting thereby. Failure to provide written notice to the *group* will not delay or prevent termination of the marriage or domestic partnership. If the *subscriber* notifies the *group* in writing to cancel coverage for a former *spouse* or *domestic partner* and the *children* of the *spouse* or *domestic partner*, if any, immediately upon termination of the *subscriber's* marriage or domestic partnership, such notice will be considered compliance with the requirements of this provision.

You may be entitled to continued benefits under terms which are specified elsewhere under CONTINUATION OF COVERAGE and EXTENSION OF BENEFITS.

CONTINUATION OF COVERAGE

Most employers who employ 20 or more people on a typical business day are subject to The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If the employer who provides coverage under the *agreement* is subject to the federal law which governs this provision (Title X of P. L. 99-272), you may be entitled to a continuation of coverage. Check with your employer for details.

DEFINITIONS

The meanings of key terms used in this section are shown below. Whenever any of the terms shown below appear in these provisions, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this "Definitions" provision.

Initial Enrollment Period is the period of time following the original Qualifying Event, as indicated in the "Terms of COBRA Continuation" provisions below.

Qualified Beneficiary means: (a) a person enrolled for this COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this *agreement* as either a *subscriber* or *family member;* or (b) a *child* who is born to or placed for adoption with the *subscriber* during the COBRA continuation period. Qualified Beneficiary does not include any person who was not enrolled during the Initial Enrollment Period, including any *family members* acquired during the COBRA continuation period, with the exception of newborns and adoptees as specified above. It does not include *domestic partners* if they are eligible under WHO'S COVERED AND WHEN.

Qualifying Event means any one of the following circumstances which would otherwise result in the termination of your coverage under the *agreement*. The events will be referred to throughout this section by number.

1. **For Subscribers and Family Members:**

    a. The *subscriber's* termination of employment, for any reason other than gross misconduct; or

    b. Loss of coverage under an employer's health plan due to a reduction in the *subscriber's* work hours.

3. **For Family Members:**

    a. The death of the *subscriber;*

    b. The ***spouse's*** divorce or legal separation from the *subscriber;*

    c. The end of a ***child's*** status as a dependent *child,* as defined by the *agreement;* or

    d. The ***subscriber's*** entitlement to Medicare.

ELIGIBILITY FOR COBRA CONTINUATION

A *subscriber* or *family member*, **other than a *domestic partner,* and a *child* of a *domestic partner***, may choose to continue coverage under the *agreement* if your coverage would otherwise end due to a Qualifying Event.

Entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 1(a) and 1(b).

TERMS OF COBRA CONTINUATION

Notice. The *group* or its administrator (we are not the administrator) will notify either the *subscriber* or *family member* of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Events 1, the *group* or its administrator will notify the *subscriber* of the right to continue coverage.

2. For Qualifying Events 2(a) or 2(d) above, a *family member* will be notified of the COBRA continuation right.

3. You must inform the *group* within 60 days of Qualifying Events 2(b) or 2(c) above if you wish to continue coverage. The *group* in turn will promptly give you official notice of the COBRA continuation right.

If you choose to continue coverage you must notify the *group* within 60 days of the date you receive notice of your COBRA continuation right. The COBRA continuation coverage may be chosen for all *members* within a family, or only for selected *members*.

If you fail to elect the COBRA continuation during the Initial Enrollment Period, you may not elect the COBRA continuation at a later date.

Notice of continued coverage, along with the initial subscription charge, must be delivered to us by the *group* within 45 days after you elect COBRA continuation coverage.

Additional Family Members. A *spouse* or *child* acquired during the COBRA continuation period is eligible to be enrolled as a *family member*. The standard enrollment provisions of the *agreement* apply to enrollees during the COBRA continuation period.

Cost of Coverage. The *group* may require that you pay the entire cost of your COBRA continuation coverage. This cost, called the "subscription charge", must be remitted to the *group* each month during the COBRA continuation period. We must receive payment of the subscription charge each month from the *group* in order to maintain the coverage in force.

Besides applying to the *subscriber,* the *subscriber's* rate also applies to:

1. A *spouse* whose COBRA continuation began due to divorce, separation or death of the *subscriber;*

2. A *child* if neither the *subscriber* nor the *spouse* has enrolled for this COBRA continuation coverage (if more than one *child* is so enrolled, the subscription charge will be the two-party or three-party rate depending on the number of *children* enrolled); and

3. A *child* whose COBRA continuation began due to the person no longer meeting the dependent *child* definition.

Subsequent Qualifying Events. Once covered under the COBRA continuation, it's possible for a second Qualifying Event to occur. If that happens, a *member,* who is a Qualified Beneficiary, may be entitled to an extended COBRA continuation period. This period will in no event continue beyond 36 months from the date of the first qualifying event.

For example, a *child* may have been originally eligible for this COBRA continuation due to termination of the *subscriber's* employment, and enrolled for this COBRA continuation as a Qualified Beneficiary. If, during the COBRA continuation period, the *child* reaches the upper age limit of the *plan,* the *child* is eligible for an extended continuation period which would end no later than 36 months from the date of the original Qualifying Event (the termination of employment).

When COBRA Continuation Coverage Begins. When COBRA continuation coverage is elected during the Initial Enrollment Period and the subscription charge is paid, coverage is reinstated back to the date of the original Qualifying Event, so that no break in coverage occurs.

For *family members* properly enrolled during the COBRA continuation, coverage begins according to the enrollment provisions of the *agreement*.

When the COBRA Continuation Ends. This COBRA continuation will end on the earliest of:

1. The end of 18 months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours of the *subscriber*;*
2. The end of 36 months from the Qualifying Event, if the Qualifying Event was the death of the *subscriber,* divorce or legal separation, or the end of dependent *child* status;*
3. The end of 36 months from the date the *subscriber* became entitled to Medicare, if the Qualifying Event was the *subscriber's* entitlement to Medicare. If entitlement to Medicare does not result in coverage terminating and Qualifying Event 1 occurs within 18 months after Medicare entitlement, coverage for Qualified Beneficiaries other than the *subscriber* will end 36 months from the date the *subscriber* became entitled to Medicare;
4. The date the *agreement* terminates;
5. The end of the period for which subscription charges are last paid;
6. The date, following the election of COBRA, the *member* first becomes covered under any other group health plan; or
7. The date, following the election of COBRA, the *member* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

*For a *member* whose COBRA continuation coverage began under a *prior plan,* this term will be dated from the time of the Qualifying Event under that *prior plan*.

Other Coverage Options Besides COBRA Continuation Coverage. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance

Marketplace, Medicaid, or other group health plan coverage options (such as a *spouse's* plan) through the conditions listed under the SPECIAL ENROLLMENT PERIODS provision. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

If at the time of termination of employment or reduction in hours, or at any time during the first 60 days of the COBRA continuation, a Qualified Beneficiary is determined to be disabled for Social Security purposes, all covered *members* may be entitled to up to 29 months of continuation coverage after the original Qualifying Event.

Eligibility for Extension. To continue coverage for up to 29 months from the date of the original Qualifying Event, the disabled *member* must:

1. Satisfy the legal requirements for being totally and permanently disabled under the Social Security Act; and
2. Be determined and certified to be so disabled by the Social Security Administration.

Notice. The *member* must furnish the *group* with proof of the Social Security Administration's determination of disability during the first 18 months of the COBRA continuation period and no later than 60 days after the later of the following events:

1. The date of the Social Security Administration's determination of the disability;
2. The date on which the original Qualifying Event occurs;
3. The date on which the Qualified Beneficiary loses coverage; or
4. The date on which the Qualified Beneficiary is informed of the obligation to provide the disability notice.

Cost of Coverage. For the 19th through 29th months that the total disability continues, the *group* must remit the cost for the extended

continuation coverage to us. This cost (called the "subscription charge") shall be subject to the following conditions:

1. If the disabled *member* continues coverage during this extension, this charge shall be **150%** of the applicable rate for the length of time the disabled *member* remains covered, depending upon the number of covered dependents. If the disabled *member* does not continue coverage during this extension, this charge shall remain at **102%** of the applicable rate.

2. The cost for extended continuation coverage must be remitted to us by the *group* each month during the period of extended continuation coverage. We must receive timely payment of the subscription charge each month from the *group* in order to maintain the extended continuation coverage in force.

3. The *group* may require that you pay the entire cost of the extended continuation coverage.

If a second Qualifying Event occurs during this extended continuation, the total COBRA continuation may continue for up to 36 months from the date of the first Qualifying Event. The subscription charge shall then be **150%** of the applicable rate for the 19th through 36th months if the disabled *member* remains covered. The charge will be **102%** of the applicable rate for any periods of time the disabled *member* is not covered following the 18th month.

When The Extension Ends. This extension will end at the earlier of:

1. The end of the month following a period of 30 days after the Social Security Administration's final determination that you are no longer totally disabled;

2. The end of 29 months from the Qualifying Event;

3. The date the *agreement* terminates;

4. The end of the period for which subscription charges are last paid;

5. The date, following the election of COBRA, the *member* first becomes covered under any other group health plan; or

6. The date, following the election of COBRA, the *member* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

You must inform the *group* within 30 days of a final determination by the Social Security Administration that you are no longer totally disabled.

EXTENSION OF BENEFITS

If you are a *totally disabled subscriber* or a *totally disabled family member* and under the treatment of a *dentist* on the date of discontinuance of the *agreement*, your benefits may be continued for treatment of the totally disabling dental condition. This extension of benefits is not available if you become covered under another group health plan that provides coverage without limitation for your disabling condition. Extension of benefits is subject to the following conditions:

1. If you wish to apply for total disability benefits, you must do so by submitting written certification by your *dentist* of the total disability. We must receive this certification within 90 days of the date coverage ends under this *plan*. At least once every 90 days while benefits are extended, we must receive proof that your total disability is continuing.

2. Your extension of benefits will end when any one of the following circumstances occurs:

    a. You are no longer totally disabled.

    b. The maximum benefits available to you under this *plan* are paid.

    c. You become covered under another group plan which provides benefits without limitation for your disabling dental condition.

    d. A period of up to 12 months has passed since your extension began.

GENERAL PROVISIONS

Providing of Care. We are not directly responsible for providing dental services, therefore we are not responsible for the care received.

Independent Contractors. Our relationship with the *participating dental office* is that of an independent contractor. *Participating dentists* and other dental health professionals within the *participating dental office* are not our agents or employees nor are we, or any of our employees, an employee or agent of any *participating dental office*.

Terms of Coverage

1. In order for you to be entitled to benefits under the *agreement*, both the *agreement* and your coverage under the *agreement* must be in effect on the date the *covered service* is provided.

2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the *covered service* is provided.

3. The *agreement* is subject to amendment, modification or termination according to the provisions of the *agreement* without your consent or concurrence.

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.

Protection of Coverage. We do not have the right to cancel your coverage under this *plan* while:

1. This *plan* is still in effect; and

2. You are eligible; and

3. Your subscription charges are paid according to the terms of the *agreement;* and

4. You live or work within your *participating dental office*'s *enrollment area;* and

5. You pay all *co-payments* due at the time services are received.

Provider Reimbursement. *Participating dental offices* are generally paid a capitation fee, a set and agreed to dollar amount per *member* each month, for dental services, and may receive additional reimbursement for overall efficiency. *Participating specialty offices* are paid on a fee-for-service basis, according to an agreed schedule for providing specialty care. *Participating dental offices* may also receive additional compensation related to the management of services and referrals. The terms of these arrangements may vary by *participating dental office*. For additional information you may contact us at the telephone number listed on your identification card or your *participating dental office*.

Medical/Dental Necessity. The benefits of this *plan* are provided only for services that we determine to be *medically necessary* for dental health.

The services must be prescribed by the *participating dentist* for the direct care and treatment of a covered dental service. They must be standard dental procedures, recognized by the American Dental Association, received for the dental condition being treated and must be legal in the United States. The process used to authorize or deny health care services under this *plan* is available to you upon request.

Expense in Excess of Benefits. We are not liable for any expense you incur in excess of the benefits of this *plan*.

Benefits Not Transferable. Only *members* are entitled to receive benefits under this *plan*. The right to benefits cannot be transferred.

Plan Administrator - COBRA and ERISA. In no event will we be plan administrator for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERISA). The term "plan administrator" refers either to the *group* or to a person or entity, other than us, engaged by the *group* to perform or assist in performing administrative tasks in connection with the *group's* health plan. The *group* is responsible for satisfaction of notice, disclosure and other obligations of administrators under ERISA. In providing notices and otherwise performing under the CONTINUATION OF COVERAGE section of this booklet, the *group* is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agent.

Prepayment Fees. Your employer is responsible for paying subscription charges to us for all coverage provided to you and your *family members*. Your employer may require that you contribute all or part of the costs of these subscription charges. Please consult your employer for details.

Liability of Subscriber to Pay Providers. In accordance with California law, you will not be required to pay any participating provider for amounts we owe to that provider, even in the unlikely event that we fail to pay that provider. You are, however, liable for services which are not covered by this *plan*.

Financial Responsibility. In the event you transfer or terminate enrollment from your *participating dental office*, any costs to transfer or duplicate the dental records and/or x-rays to the new office will be your financial responsibility and subject to the customary and reasonable fees of the *participating dental office*, not to exceed **$25**. If you reside or change your permanent residence or employment location outside of the Dental Net Service area, and decide to have care provided or treatment

completed by a dental office other than your *participating dental office*, you and NOT us will be financially responsible.

Renewal Provisions. Your employer's health plan *agreement* with us is subject to renewal at certain intervals. We may change the subscription charges or other terms of the *plan* from time to time.

Public Policy Participation. We have established a Public Policy Committee (that we call our Consumer Relations Committee) to advise our Board of Directors. This Committee advises the Board about how to assure the comfort, dignity, and convenience of the people we cover. The Committee consists of members covered by our health plan, participating providers and a member of our Board of Directors. The Committee may review our financial information and information about the nature, volume, and resolution of the complaints we receive. The Consumer Relations Committee reports directly to our Board.

Conformity with Laws. Any provision of the *agreement* which, on its effective date, is in conflict with the laws of the governing jurisdiction, is hereby amended to conform to the minimum requirements of such laws.

Confidentiality of Medical Records. A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

Transition Assistance for New *Members*: Transition Assistance is a process that allows for completion of covered services for new *members* receiving services from a dental office or *dentist* who does not have a Participating Dental Net Agreement in effect with us. If you are a new *member*, you may request Transition Assistance if any one of the following conditions applies:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to

another provider, as determined by Anthem in consultation with you and the *non-participating dentist* and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll with Anthem.

3. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.

4. The care of a newborn *child* between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the time the *child* enrolls with Anthem.

5. Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the time you enroll with Anthem.

Please contact Member Services at the telephone number listed on your ID card to request Transition Assistance or to obtain a copy of the written policy. Eligibility is based on your clinical condition and is not determined by diagnostic classifications. Transition Assistance does not provide coverage for services not otherwise covered under the *plan*.

We will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for Transition Assistance is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the *plan*. Financial arrangements with *non-participating dentists* are negotiated on a case-by-case basis. We will request that the *non-participating dentist* agree to accept reimbursement and contractual requirements that apply to *participating dentists*, including payment terms, who are not capitated. If the *non-participating dentist* does not agree to accept said reimbursement and contractual requirements, we are not required to continue that provider's services. If you do not meet the criteria for Transition Assistance, you are afforded due process including having a *dentist* review the request.

Continuity of Care after Termination of Provider: Subject to the terms and conditions set forth below, Anthem will provide benefits at the *participating dentist* level for covered services (subject to applicable copayments, coinsurance, deductibles and other terms) received from a *participating dental office* at the time the *participating dental office's* contract with us terminates (unless the *participating dental office's* contract terminates for reasons of medical disciplinary cause or reason, fraud, or other criminal activity).

You must be under the care of the *participating dental office* at the time the *participating dental office's* contract terminates. The terminated dental office must agree in writing to provide services to you in accordance with the terms and conditions of the agreement with Anthem prior to termination. The dental office must also agree in writing to accept the terms and reimbursement rates that apply to *participating dentists* who are not capitated. If the dental office does not agree with these contractual terms and conditions, we are not required to continue the dental office's services beyond the contract termination date.

Anthem will provide such benefits for the completion of covered services by a terminated dental office only for the following conditions:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Anthem in consultation with you and the terminated dental office and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the dental office's contract terminates.

3. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.

4. The care of a newborn *child* between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.

5. Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the date the provider's contract terminates.

Such benefits will not apply to dental offices that have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity.

Please contact Member Services at the telephone number listed on your ID card to request continuity of care or to obtain a copy of the written policy. Eligibility is based on the *member's* clinical condition and is not determined by diagnostic classifications. Continuity of care does not provide coverage for services not otherwise covered under the *plan*.

We will notify you by telephone, and the dental office by telephone and fax, as to whether or not your request for continuity of care is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the *plan*. Financial arrangements with terminated dental offices are negotiated on a case-by-case basis. We will request that the terminated dental office agree to accept reimbursement and contractual requirements that apply to *participating dental offices*, including payment terms, who are not capitated. If the terminated dental office does not agree to accept the same reimbursement and contractual requirements, we are not required to continue that dental office's services. If you disagree with our determination regarding continuity of care, you may file a grievance with us by following the procedures described in the section entitled GRIEVANCE PROCEDURES.

This provision also applies if the contractual or employment relationship between your *participating dental office* and the *participating dentist* or *participating specialist* from whom you are receiving care terminates.

GRIEVANCE PROCEDURES

1. If you are dissatisfied or have a grievance regarding services under this *agreement*, contact your *participating dental office*.

If you are unable to resolve your concerns with the *participating dental office*, you should submit a formal complaint to us, in writing, including all pertinent information from your Dental Net identification card and the details and circumstances of your concern or problem. You can get a copy of the grievance form from us. Complete the form and mail it to us or you may call us at the Dental Net Member Services telephone number listed on your identification card and ask the Member Services representative to complete the form for you. You may also submit your grievance to us online or print a copy of the grievance form through the Anthem Blue Cross website at **www.anthem.com/ca**. You must submit your grievance to us no later than 180 days following the date you receive a denial notice from us or your *participating dental office* or any other incident or action with which you are dissatisfied. Your issue will then become part of our formal grievance process and will be resolved accordingly.

We will request all pertinent information regarding your concerns from all parties involved. Upon receipt of all requested information, we will review and, if possible, resolve the matter. We should be allowed thirty (30) days after receipt of the complaint and all necessary information to reach a resolution.

If your case is urgent and involves an imminent threat to your health, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, review of your grievance will be expedited and resolved within three days.

If your concern or problem with the services provided by your *participating dental office* cannot be resolved by us, we may recommend that the complaint be submitted for impartial review to the California Dental Association's Peer Review process or to another qualified mediator for impartial review and settlement.

2. If you are dissatisfied or have a concern with Dental Net, contact our Dental Member Services department indicated on your identification card. If we are unable to resolve your concerns, you should submit a formal complaint as described above requesting review by the Grievance Committee. This committee is comprised of the following: The Dental Net Dental Director, the Compliance Manager, Professional Relations staff representatives, the Manager of Quality Assurance, Member Services staff representative and three grievance coordinators.

The Grievance Committee shall be allowed thirty (30) days after receipt of the complaint and all necessary information to reach a resolution. Within five (5) days after receipt of the grievance, we will acknowledge receipt. After we have reviewed your grievance we will send you a written statement on its resolution within 30 days. If your case involves an imminent threat to your health, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, review of your grievance will be expedited and resolved within three days.

3. If you are dissatisfied with the resolution of your grievance, or if your grievance has not been resolved after at least 30 days, you may submit your grievance to the California Department of Managed Health Care for review prior to binding arbitration (see DEPARTMENT OF MANAGED HEALTH CARE). If your case involves an imminent threat to your health, as described above, you are not required to complete our grievance process or to wait at least 30 days, but may immediately submit your concerns to the Department of Managed Health Care for review.

4. If at the conclusion of review of your grievance by the Department of Managed Health Care you continue to be dissatisfied with its resolution, or prior to and instead of review of your case by the Department of Managed Health Care, you may elect binding arbitration (see BINDING ARBITRATION).

Independent Medical Review of Denials of Experimental or Investigative Treatment

If coverage for a proposed treatment is denied because we or your *participating dental office* determine that the treatment is *experimental* or *investigative*, you may ask that the denial be reviewed by an external independent medical review organization contracting with the Department of Managed Health Care ("DMHC"). Your request for this review may be submitted to the DMHC. You pay no application or processing fees of any kind for this review. You have the right to provide information in support of your request for review. A decision not to participate in this review process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service. You will receive an application form and an addressed envelope for you to use to request this review with any grievance disposition letter denying coverage for this reason. You may also request an application form by calling us at the telephone number listed on your identification card or write to us at Anthem Blue Cross Dental Net Grievance Department, P.O. Box 659471, San

Antonio, TX. 78265 - 9471. To qualify for this review, all of the following conditions must be met:

- You have a life-threatening or seriously debilitating condition, described as follows:
    - ♦ A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the disease is interrupted or a condition or disease with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
    - ♦ A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.
- Your *participating dental office* must certify that either (a) standard treatment has not been effective in improving your condition, (b) standard treatment is not medically appropriate, or (c) there is no more beneficial standard treatment covered by this *plan* than the proposed treatment.
- The proposed treatment must either be:
    - ♦ Recommended by a *participating dentist* who certifies in writing that the treatment is likely to be more beneficial than standard treatments, or
    - ♦ Requested by you or by a licensed board certified or board eligible *dentist* qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources:
        a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;
        b) Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR);

c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;

d) Either of the following: (i) The American Hospital Formulary Service's Drug Information, or (ii) the American Dental Association Accepted Dental Therapeutics;

e) Any of the following references, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i) the Elsevier Gold Standard's Clinical Pharmacology, (ii) the National Comprehensive Cancer Network Drug and Biologics Compendium, or (iii) the Thomson Micromedex DrugDex;

f) Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and

g) Peer reviewed abstracts accepted for presentation at major medical association meetings.

In all cases, the certification must include a statement of the evidence relied upon.

You must request this review within six months of the date you receive a denial notice in response to your grievance, or from the end of the 30 day or three day grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

Within three business days of receiving notice from the DMHC of your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your *participating dental office*. Any newly developed or discovered relevant medical records identified by us or by a *participating dentist* after the initial documents are sent will be immediately forwarded to the reviewing panel. The external independent review organization will complete its review and render its opinion within 30 days

of its receipt of request for review (or within seven days if your *participating dental office* determines that the proposed treatment would be significantly less effective if not provided promptly). This timeframe may be extended by up to three days for any delay in receiving necessary records.

Please note: If you have a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less) and proposed treatment is denied because the treatment is determined to be *experimental*, you may also meet with our review committee to discuss your case as part of the grievance process (see GRIEVANCE PROCEDURES).

Independent Medical Review of Grievances Involving a Disputed Health Care Service

You may request an independent medical review ("IMR") of disputed health care services from the Department of Managed Health Care ("DMHC") if you believe that we or your *participating dental office* have improperly denied, modified, or delayed health care services. A "disputed health care service" is any health care service eligible for coverage and payment under your *plan* that has been denied, modified, or delayed by us or your *participating dental office*, in whole or in part because the service is not *medically necessary*.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. We must provide you with an IMR application form and an addressed envelope for you to use to request IMR with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service.

Eligibility: The DMHC will review your application for IMR to confirm that:

1. One or more of the following conditions has been met:

   (a) Your *dentist* has recommended a health care service as *medically necessary*,

   (b) You have received *urgent care* or *emergency services* that a *dentist* determined was *medically necessary*, or

(c) You have been seen by a *participating dentist* for the diagnosis or treatment of the medical condition for which you seek independent review;

2. The disputed health care service has been denied, modified, or delayed by us or your *participating dental office*, based in whole or in part on a decision that the health care service is not *medically necessary*; and

3. You have filed a grievance with us or your *participating dental office* and the disputed decision is upheld or the grievance remains unresolved after 30 days. If your grievance requires expedited review you need not participate in our grievance process for more than three days. The DMHC may waive the requirement that you follow our grievance process in extraordinary and compelling cases.

You must apply for IMR within six months of the date you receive a denial notice from us or your *participating dental office* in response to your grievance or from the end of the 30 day or three day grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

If your case is eligible for IMR, the dispute will be submitted to a medical specialist or specialists who will make an independent determination of whether or not the care is *medically necessary*. You will receive a copy of the assessment made in your case. If the IMR determines the service is *medically necessary*, we will provide the health care service.

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within 30 days of receipt of your application and supporting documents. For urgent cases involving an imminent and serious threat to your health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health, the IMR organization must provide its determination within 3 days.

For more information regarding the IMR process, or to request an application form, please call us at the Member Services telephone number listed on your ID card.

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-627-0004** or at the TDD/TTY line **711** for the hearing and speech impaired and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.

BINDING ARBITRATION

Note: If you are enrolled in a *plan* provided by your employer that is subject to ERISA, any dispute involving an adverse benefit decision must be resolved under ERISA's claims procedure rules, and is not subject to mandatory binding arbitration. You may pursue voluntary binding arbitration after you have completed an appeal under ERISA. If you have any other dispute which does not involve an adverse benefit decision, this BINDING ARBITRATION provision applies.

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this *plan* or the *agreement*, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this BINDING ARBITRATION provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate shall apply.

The *member* and Anthem agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to trial by jury for both medical malpractice claims and any other disputes.

California Health & Safety Code section 1363.1 requires that any arbitration agreement include the following notice based on California Code of Civil Procedure 1295(a): **It is understood that any dispute as to medical malpractice, that is, whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings and except for disputes regarding a claim for damages within the jurisdictional limits of the small claims court. Both parties to this contract, by entering into it, acknowledge that they are giving up their constitutional right to have any and all disputes, including medical malpractice claims, decided in a court of law before a jury, and instead are accepting the use of arbitration.**

The *member* and Anthem agree to give up the right to participate in class arbitrations against each other. Even if applicable law permits class actions or class arbitrations, the *member* waives any right to pursue, on a class basis, any such controversy or claim against Anthem and Anthem waives any right to pursue on a class basis any such controversy or claim against the *member*.

The arbitration findings will be final and binding except to the extent that state or federal law provides for the judicial review of arbitration proceedings.

The arbitration is initiated by the *member* making written demand on Anthem. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS"), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by agreement of the *member* and Anthem, or by order of the court, if the *member* and Anthem cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, Anthem will assume all or a portion of the costs of the arbitration.

Please send all Binding Arbitration demands in writing to Anthem Blue Cross, P.O. Box 4310, Woodland Hills, CA 91365-4310 marked to the attention of the Member Services Department listed on your identification card.

COORDINATION OF BENEFITS

If you are covered by more than one group dental plan, your benefits under This Plan will be coordinated with the benefits of those Other Plans, as shown below. These coordination provisions apply separately to each *member*, per *year*, and are largely determined by California law.

DEFINITIONS

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appear in these provisions, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this "Definitions" provision.

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by any plan covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid. An expense that is not covered by any plan covering the person for whom claim is made is not an Allowable Expense.

The following are not Allowable Expense:

1. Use of a private hospital room is not an Allowable Expense unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for hospital private rooms.

2. If you are covered by two plans that calculate benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method, any amount in excess of the higher of the reasonable and customary amounts.

3. If a person is covered by two plans that provide benefits or services on the basis of negotiated rates or fees, an amount in excess of the lower of the negotiated rates.

4. If a person is covered by one plan that calculates its benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method and another plan provides its benefits or services on the basis of negotiated rates or fees, any amount in excess of the negotiated rate.

5. The amount of any benefit reduction by the Principal Plan because you did not comply with the plan's provisions is not an Allowable Expense. Examples of these types of provisions include second surgical opinions, utilization review requirements, and network provider arrangements.

6. If you advise us that all plans covering you are high deductible health plans as defined by Section 223 of the Internal Revenue Code, and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code, any amount that is subject to the primary high deductible health plan's deductible.

Other Plan is any of the following:

1. group, blanket or franchise insurance coverage;

2. group service plan contract, group practice, group individual practice and other group prepayment coverages;

3. group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.

The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or other arrangement which reserves the right to take the services or benefits of Other Plans into consideration in determining its benefits.

Principal Plan is that plan which will have its benefits determined first.

This Plan is that portion of this *plan* which provides benefits subject to this provision.

EFFECT ON BENEFITS

This provision will apply in determining a person's benefits under This Plan for any *calendar year* if the benefits under This Plan and any Other Plans, exceed the Allowable Expenses for that *calendar year*.

1. If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.

2. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all of the plans do not exceed the Allowable Expense.

3. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

If This Plan is not the Principal Plan, you may be billed by a *dentist* or other provider of dental care.

ORDER OF BENEFITS DETERMINATION

The first of the following rules which applies will determine the order in which benefits are payable:

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision.

2. A plan which covers you as a *subscriber* pays before a plan which covers you as a dependent.

3. For a dependent *child* covered under plans of two parents, the plan of the parent whose birthday falls earlier in the *calendar year* pays before the plan of the parent whose birthday falls later in the *year*. But, if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

   Exception to Rule 3: For a dependent *child* of parents who are divorced or separated, the following rules will be used in place of Rule 3:

   a. If the parent with custody of that *child* for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that *child* as a dependent pays first.

   b. If the parent with custody of that *child* for whom a claim has been made has remarried, then the order in which benefits are provided will be as follows:

      i. The plan which covers that *child* as a dependent of the parent with custody.

      ii. The plan which covers that *child* as a dependent of the stepparent (married to the parent with custody).

iii. The plan which covers that *child* as a dependent of the parent without custody.

iv. The plan which covers that *child* as a dependent of the stepparent (married to the parent without custody).

c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that *child's* health care coverage, a plan which covers that *child* as a dependent of that parent pays first.

4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But, if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.

5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the order of benefit determination provisions of This Plan, this rule will not apply.

6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

OUR RIGHTS UNDER THIS PROVISION

Responsibility for Timely Notice. We are not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.

Reasonable Cash Value. If any Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and our liability reduced accordingly.

Facility of Payment. If payments which should have been made under This Plan have been made under any Other Plan, we have the right to pay that Other Plan any amount we determine to be warranted to satisfy the

intent of this provision. Any such amount will be considered a benefit paid under This Plan, and such payment will fully satisfy our liability under this provision.

Right of Recovery. If payments made under This Plan exceed the maximum payment necessary to satisfy the intent of this provision, your *participating dental office* and we have the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

DEFINITIONS

The meanings of key terms used in this booklet are shown below. Whenever any of the key terms shown below appear, it will appear in italicized letters. When any of the terms below are italicized in this booklet, you should refer to this section.

Agreement is the Group Benefit Agreement issued by us to the *group*.

Anthem Blue Cross (Anthem) is a health care service plan, regulated by the California Department of Managed Health Care pursuant to the Knox-Keene Health Care Service Act of 1975.

Child meets the *plan's* eligibility requirements for children as outlined under WHO'S COVERED AND WHEN.

Co-payment is the amount of payment indicated in the SCHEDULE OF CO-PAYMENTS. It is due and payable at the time of service by the *member* to the *participating dental office* or other provider of care.

Covered Service is any dental service received by you which meets all of the following criteria:

1. It must be received by you while you are covered under this *plan*. (An expense is considered to be incurred on the date you receive the dental service or supply for which the expense is made.);
2. It must be for a dental service or supply listed as covered in the SCHEDULE OF CO-PAYMENTS;
3. It must NOT be for a dental service or supply listed in the WHAT'S NOT COVERED AND LIMITED SERVICES section of this booklet; and
4. It must be for a dental service or supply received in accordance with the HOW TO OBTAIN CARE section under YOUR DENTAL BENEFITS.

Creditable coverage is any individual or group plan that provides medical, hospital and surgical coverage, including continuation coverage, coverage under Medicare or Medicaid, TRICARE, the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, coverage through the Peace Corps, the State Children's Health Insurance Program, or a public health plan established or maintained by a state, the United States government, or a foreign country. Creditable coverage does not include accident only, credit, coverage for on-site medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers' compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans. Creditable coverage is used to set up eligibility rules for children who cannot get a self-sustaining job due to a physical or mental condition. In addition, eligible children were covered under one of the above types of health coverage on his or her own and not as a dependent *child*.

If your prior coverage was through an employer, you will receive credit for that coverage if it ended because your employment ended, the availability of medical coverage offered through employment or sponsored by the employer terminated, or the employer's contribution toward medical coverage terminated, and any lapse between the date that coverage ended and the date you become eligible under this *plan* is no more than 180 days (not including any waiting period imposed under this *plan* by the employer).

If your prior coverage was not through an employer, you will receive credit for that coverage if any lapse between the date that coverage ended and the date you become eligible under this *plan* is no more than 63 days (not including any waiting period imposed under this *plan* by the employer).

Dental Net of California (Dental Net) is a prepaid dental care plan provided by Anthem.

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

Domestic partner meets the *plan's* eligibility requirements for domestic partners as outlined under WHO'S COVERED AND WHEN: HOW YOU ENROLL.

Effective date is the date your coverage begins under this *plan*.

Emergency services are services required for alleviation of severe pain or bleeding or swelling. Emergency services are not for continuing any treatment plan currently in process, unless it has been authorized. Final determination as to whether services were rendered in connection with an emergency will rest solely with us or *your participating dental office*.

Enrollment area (service area) is defined as the geographical area within a 15- mile or 30-minute radius of the *participating dental office* selected by the *subscriber*.

Experimental or investigative procedures are those that are not recognized and accepted by the American Dental Association (ADA) as standard dental practice.

Family member is the *subscriber*'s enrolled *spouse* and each enrolled *child*.

Full-time employee meets the *plan's* eligibility requirements for full-time employees as outlined under WHO'S COVERED AND WHEN.

Group refers to the business entity to which we have issued this *agreement*. The name of the group is THE AEROSPACE CORPORATION.

Medically necessary services or supplies are those we determine to be:

- Appropriate and necessary for the diagnosis or treatment of the dental condition, and
- Within standards of good dental practice within the organized dental community, and
- Not primarily for your convenience, or for the convenience of your *dentist*, physician or another provider.

Member is the *subscriber* or *family member*.

Non-participating dentist is a *dentist* who has not entered into a Participating Dental Net Agreement with us at the time services are rendered.

Orthodontia - Phase I Treatment (Primary and or Transitional Dentition) is the use of either fixed or removable appliances in the upper or lower arches, or both. It includes the treatment of such problems as cross bite, arch width, distance between the arches and deep overbite or overjet.

Orthodontia - Phase II Treatment (Adolescent or Adult Dentition) is the use of generally fixed appliances to definitely move the teeth within the jaws. May include refinement of less severe problems commonly treated in Phase I. (Standard 24 month treatment plan).

Participating dental office is a *dentist*, or a group of *dentists* organized as a legal entity, which has an agreement in effect with us to furnish dental care to *members*, and which has been selected by the *subscriber* to provide the services covered under this *plan*.

Participating dentist is a licensed *dentist* at a *participating dental office* which has an agreement in effect with us to furnish dental care to *members*.

Participating orthodontic office is a licensed orthodontist, or a group of orthodontists organized as a legal entity, which has an agreement in effect with us to furnish orthodontic care to *members*, and which has been selected by the *subscriber* to provide the orthodontic services covered under this *plan*.

Participating orthodontist is a licensed dentist (orthodontist) who has completed an advanced education program at an institution accredited by the American Dental Association, or American Orthodontic Association; who has a practice limited to providing orthodontic services and has contracted with us to provide orthodontic services to *members*; and is an owner, associate or employee of a *participating orthodontic office*.

Participating specialist is a licensed *dentist* who has completed an advanced education program at an institution accredited by the American Dental Association, or Government entity, who has a practice limited to providing specialty services, and has contracted with us to provide specialty services to *members*, and is an owner, associate or employee of the *participating specialty office*.

Participating specialty office is the dental office which will provide authorized *specialty referral services* which you are entitled to under this *plan*. All specialty services received at a participating specialty office must be authorized by us. All participating specialty offices have contracted with us to provide specialty services to *members*.

Physician means a licensed practitioner of the healing arts acting within the scope of their license.

Plan is the set of benefits described in this booklet and in the amendments to this booklet, if any. This plan is subject to the terms and conditions of the *agreement* we have issued to the *group*. If changes are made to the plan, an amendment or revised booklet will be issued to the *group* for distribution to each *subscriber* affected by the change. (The word "plan" here does not mean the same as plan as used in ERISA.)

Prior Plan is a plan sponsored by the *group* which was replaced by this *plan* 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 *plan's* effective date; and (3) had coverage terminate solely due to the prior plan's termination.

Specialty Referral Services are specialty services rendered by a *participating specialty office* which: (1) have been authorized by us; or (2) have been rendered to a *member* referred in an emergency by the *participating dental office* and which constitute *emergency services.*

Spouse meets the *plan's* eligibility requirements for spouses as outlined under WHO'S COVERED AND WHEN.

Subscriber is the person who, by meeting the *plan's* eligibility requirements for subscribers, is allowed to choose membership under this *plan* for himself or herself and his or her eligible *family members*. Such requirements are outlined in WHO'S COVERED AND WHEN.

Totally disabled family member is a *family member* who is unable to perform all activities usual for persons of that age.

Totally disabled subscriber is a *subscriber* who, because of dental illness or injury, is unable to work for income in any job for which he/she is qualified or for which he/she becomes qualified by training or experience, and who is in fact unemployed.

We (us, our) refers to Anthem Blue Cross.

Year or calendar year is a 12 month period starting January 1 at 12:01 a.m. Pacific Standard Time.

You (your) refers to the *subscriber* and *family members* who are enrolled for benefits under this *plan*.

Your participating dental office is the *participating dental office* which will either provide or authorize the dental care to which you are entitled under this *plan*.

Your participating dentist refers to the *participating dentist* from the staff of your *participating dental office* who will be the primary provider of your dental care while you are enrolled as a Dental Net *member* in that *participating dental office*.

SCHEDULE OF CO-PAYMENTS FOR PLAN 550

The services which are provided for the treatment of covered dental benefits are listed below. **All services must be authorized by *your participating dentist* or Anthem.** Included in the list of covered services are the *co-payment* amounts you will be required to pay for certain services. All services are subject to the WHAT'S NOT COVERED AND LIMITED SERVICES section of your Dental Net Evidence of Coverage Form.

THE SERVICES OF THIS PLAN ARE PROVIDED ONLY WHEN THEY ARE PERFORMED, PRESCRIBED, DIRECTED OR AUTHORIZED AS MEDICALLY NECESSARY BY A DENTIST IN THE PARTICIPATING DENTAL OFFICE YOU HAVE SELECTED.

DIAGNOSTIC

These are routine services which are required by your *dentist* to determine the type of treatment you may need.

COVERED SERVICES	CO-PAYMENT
Clinical Oral Examinations	
Initial oral examination	**No Charge**
Periodic oral examination	**No Charge**
Emergency oral examination	**No Charge**
X-Rays	
Intraoral – complete series	**No Charge**
Intraoral – periapical – first film	**No Charge**
Intraoral – periapical – each additional film	**No Charge**
Intraoral – occlusal film	**No Charge**
Bitewing – single film	**No Charge**
Bitewings – two films	**No Charge**
Bitewings – four films	**No Charge**
Panoramic film	**No Charge**

Tests and Consultations
Pulp vitality tests ..... **No Charge**
Consultation – per session..... **No Charge**

PREVENTIVE

These services are performed by your *dentist* or a licensed dental hygienist to help prevent certain conditions from occurring.

COVERED SERVICES **CO-PAYMENT**

Dental Prophylaxis
Prophylaxis – adult..... **No Charge**
Prophylaxis – child ..... **No Charge**

Topical Fluoride Treatment
Topical application of fluoride (child):
– Including prophylaxis..... **No Charge**
– Excluding prophylaxis ..... **No Charge**

Other Preventive Services
Oral hygiene instruction ..... **No Charge**

RESTORATIVE

These services are performed by your *dentist* to restore tooth structure lost as a result of dental decay.

COVERED SERVICES **CO-PAYMENT**

Amalgam Restorations (including polishing)
One surface, primary..... **No Charge**
Two surfaces, primary..... **No Charge**
Three surfaces, primary ..... **No Charge**
Four surfaces, primary ..... **No Charge**
One surface, permanent ..... **No Charge**
Two surfaces, permanent..... **No Charge**
Three surfaces, permanent..... **No Charge**
Four or more surfaces, permanent..... **No Charge**

RESTORATIVE (Continued)

Resin or Composite Restorations

One surface, anterior	**No Charge**
Two surfaces, anterior	**No Charge**
Three surfaces, anterior	**No Charge**
Four or more surfaces or involving incisal angle	**No Charge**

COVERED SERVICES	**CO-PAYMENT**

Other Restorative Services

Prefabricated stainless steel crown:	
– Primary tooth	**No Charge**
– Permanent tooth	**No Charge**
Prefabricated resin crown	**No Charge**
Sedative filling	**No Charge**
Crown buildup, including any pins	**No Charge**
Pin retention – per tooth, in addition to restoration	**No Charge**

ENDODONTICS

These services are performed by your *dentist* to treat diseases of the tooth pulp nerve and its associated structures.

COVERED SERVICES	**CO-PAYMENT**

Pulp Capping

Pulp cap – direct	**No Charge**
Pulp cap – indirect	**No Charge**

Pulpotomy

Therapeutic pulpotomy	**No Charge**

Root Canal Therapy (including treatment plan, clinical procedures, and follow-up care)

One canal	**$ 60.00**
Two canals	**$ 80.00**
Three or four canals	**$ 100.00**

Periapical Services

Apicoectomy (per tooth) – first root	**$ 90.00**
Apicoectomy (per tooth) – each additional root	**$ 20.00**
Retrograde filling – per root	**$ 100.00**

PERIODONTICS

These services are performed by your *dentist* or a licensed dental hygienist to treat diseases of the gums and supporting structures.

COVERED SERVICES	**CO-PAYMENT**
Surgery (including usual postoperative services)	
Gingivectomy or gingivoplasty – per quadrant	**$ 60.00**
Gingivectomy or gingivoplasty – per tooth	**$ 9.00**
Gingival curettage – per quadrant	**$ 18.00**
Osseous surgery – per quadrant	**$ 120.00**
Adjunctive Periodontal Services	
Periodontal scaling and root planing – per quadrant	**$ 18.00**

PROSTHODONTICS

These services are performed by your *dentist* to repair tooth structure lost as a result of dental decay or to replace missing teeth with full or partial dentures, crowns and bridges.

COVERED SERVICES	**CO-PAYMENT**
Space Maintenance (passive appliances)	
Space maintainer – fixed – unilateral	**$ 45.00**
Space maintainer – fixed – bilateral	**$ 45.00**
Space maintainer – removable – unilateral	**$ 45.00**
Space maintainer – removable – bilateral	**$ 45.00**
Recement of space maintainer	**$ 5.00**
Inlay Restorations	
Inlay metallic – two surfaces*	**$ 90.00**
Inlay metallic – three surfaces*	**$ 100.00**
Onlay – metallic – per tooth (in addition to inlay)*	**$ 10.00**

* Plus actual costs for noble/high (precious) metal

PROSTHODONTICS (Continued)

COVERED SERVICES	CO-PAYMENT
Crowns – Single Restoration Only	
Crown – resin (laboratory)	**$ 85.00**
Crown – resin with high noble metal*	**$ 120.00**
Crown – resin with predominantly base metal	**$ 120.00**
Crown – resin with noble metal*	**$ 120.00**
Crown – porcelain/ceramic substrate	**$ 120.00**
Crown – porcelain fused to high noble metal*	**$ 120.00**
Crown – porcelain fused to predominantly base metal	**$ 120.00**
Crown – porcelain fused to noble metal*	**$ 120.00**
Crown – full cast high noble metal*	**$ 120.00**
Crown – full cast predominantly base metal	**$ 120.00**
Crown – full cast noble metal*	**$ 120.00**
Crown – 3/4 cast metallic*	**$ 120.00**
Other Prosthodontic Services	
Cast post and core*	**$ 60.00**
Prefabricated post and core	**$ 20.00**
Temporary crown (fractured tooth)	**$ 20.00**
Recement inlay	**$ 10.00**
Recement crown	**$ 10.00**
Complete Dentures (including routine postdelivery care)	
Complete upper	**$ 140.00**
Complete lower	**$ 140.00**
Immediate upper	**$ 140.00**
Immediate lower	**$ 140.00**
Partial Dentures (including routine postdelivery care)	
Upper partial predominantly cast base including clasps	**$ 160.00**
Lower partial predominantly cast base including clasps	**$ 160.00**
Adjustments to Dentures	
Adjust complete upper denture	**No Charge**
Adjust complete lower denture	**No Charge**
Adjust partial upper denture	**No Charge**
Adjust partial lower denture	**No Charge**

* Plus actual costs for noble/high (precious) metal

PROSTHODONTICS (Continued)

COVERED SERVICES	CO-PAYMENT
Repairs to Complete Dentures	
Repair broken complete denture base	**$ 15.00**
Replace missing or broken teeth (each tooth)	**$ 10.00**
Repairs to Partial Dentures	
Repair acrylic saddle or base	**$ 15.00**
Repair cast framework	**$ 30.00**
Repair or replace broken clasp	**$ 20.00**
Replace broken teeth – per tooth	**$ 10.00**
Add tooth to existing partial denture	**$ 30.00**
Add clasp to existing partial denture	**$ 40.00**
Denture Rebase Procedures	
Rebase complete upper denture	**$ 80.00**
Rebase complete lower denture	**$ 80.00**
Rebase partial upper denture	**$ 80.00**
Rebase partial lower denture	**$ 80.00**
Denture Reline Procedures	
Reline complete upper denture (chairside)	**$ 20.00**
Reline complete lower denture (chairside)	**$ 20.00**
Reline partial upper denture (chairside)	**$ 20.00**
Reline partial lower denture (chairside)	**$ 20.00**
Reline complete upper denture (laboratory)	**$ 50.00**
Reline complete lower denture (laboratory)	**$ 50.00**
Reline partial upper denture (laboratory)	**$ 50.00**
Reline partial lower denture (laboratory)	**$ 50.00**
Other Removable Prosthetic Services	
Temporary partial – stayplate denture (upper)	**$ 75.00**
Temporary partial – stayplate denture (lower)	**$ 75.00**
Tissue conditioning – per denture unit	**$ 25.00**

PROSTHODONTICS (Continued)

COVERED SERVICES	CO-PAYMENT
Bridge Pontics	
Pontic – cast high noble metal*	**$ 120.00**
Pontic – cast predominantly base metal	**$ 120.00**
Pontic – cast noble metal*	**$ 120.00**
Pontic – porcelain fused to high noble metal*	**$ 120.00**
Pontic – porcelain fused to predominantly base metal	**$ 120.00**
Pontic – porcelain fused to noble metal*	**$ 120.00**
Pontic – resin with high noble metal*	**$ 120.00**
Pontic – resin with predominantly base metal	**$ 120.00**
Pontic – resin with noble metal*	**$ 120.00**
Retainers	
Cast metal retainer for acid etched bridge*	**$ 55.00**
Bridge Retainers – Crowns	
Abutment crowns:	
– Resin with high noble metal*	**$ 120.00**
– Resin with predominantly base metal	**$ 120.00**
– Resin with noble metal*	**$ 120.00**
– Porcelain fused to high noble metal*	**$ 120.00**
– Porcelain fused to predominantly base metal	**$ 120.00**
– Porcelain fused to noble metal*	**$ 120.00**
– 3/4 cast high noble metal*	**$ 120.00**
– Full cast high noble metal*	**$ 120.00**
– Full cast predominantly base metal	**$ 120.00**
– Full cast noble metal*	**$ 120.00**
Other Fixed Prosthetic Services	
Recement bridge	**$ 15.00**

* Plus actual costs for noble/high (precious) metal

ORAL SURGERY

Oral surgery is performed by your *dentist* when you require an extraction, biopsy or other oral surgery.

COVERED SERVICES	**CO-PAYMENT**
Extractions (includes local anesthesia and routine postoperative care)	
Single tooth	**No Charge**
Each additional tooth	**No Charge**
Root removal – exposed roots	**No Charge**
Surgical Extractions (includes local anesthesia and routine postoperative care)	
Surgical removal of erupted tooth	**$ 25.00**
Removal of impacted tooth:	
– Soft tissue	**$ 30.00**
– Partially bony	**$ 40.00**
– Completely bony	**$ 50.00**
– Completely bony, with complications	**$ 50.00**
Root recovery (surgical removal of residual tooth roots)	**$ 30.00**
Other Surgical Procedures	
Biopsy of oral tissue – hard	**$ 10.00**
Biopsy of oral tissue – soft	**$ 10.00**
Incision/drain of abscess – intraoral soft tissue	**$ 10.00**
Repair of Traumatic Wounds	
Suture of recent small wounds up to 5 cm	**$ 20.00**

ANESTHESIA

Your *dentist* may recommend you be given an anesthetic before necessary dental procedures are performed. You may only need a local anesthetic applied directly to the area in which your *dentist* will be working.

COVERED SERVICES	**CO-PAYMENT**
Anesthesia	
Local anesthesia	**No Charge**

MISCELLANEOUS SERVICES

COVERED SERVICES	**CO-PAYMENT**
Behavior Management	**$ 25.00**
Office visit – after hours	**$ 45.00**
Emergency palliative treatment	**No Charge**

IMPORTANT NOTE: IF YOUR DENTAL OFFICE CHARGES FOR A BROKEN APPOINTMENT OR FAILURE TO CANCEL WITHOUT PROVIDING 24 HOURS ADVANCE NOTICE, THEN YOU WILL BE RESPONSIBLE FOR THIS CHARGE. THIS CHARGE IS NOT REIMBURSABLE BY US.

YOUR ORTHODONTIC BENEFITS

Your Dental Net *plan* provides the orthodontic benefits described below. Please read the following information so that you may know how to take advantage of these added benefits. These benefits are subject to all the terms, conditions, limitations and exclusions of your Evidence of Coverage Form.

Orthodontic services are provided to prevent or correct the abnormal positioning or misalignment of teeth (malocclusion).

ANY ORTHODONTIC TREATMENT MUST BE PROVIDED BY A PARTICIPATING ORTHODONTIST CONTRACTED BY US TO PROVIDE ORTHODONTIC SERVICES TO DENTAL NET MEMBERS.

HOW YOU OBTAIN CARE

If you or a *family member* require the services of an orthodontist, you should first contact the Dental Net Member Services department at (800) 627-0004 for written referral for orthodontic care. The Dental Member Services Representative will provide you with the written orthodontic referral and information you need to take with you to your first appointment with the *participating orthodontist*. This information may include a listing of the *participating orthodontic offices* through which you are eligible to receive your orthodontic benefits, a letter of eligibility indicating your benefits (to present to the orthodontist), and the eligibility verification form your *participating orthodontist* must submit to us for your benefits. **ORTHODONTIC TREATMENT PROVIDED WITHOUT A WRITTEN REFERRAL FROM US WILL BE YOUR FINANCIAL RESPONSIBILITY AND NOT OURS.**

Once you receive your orthodontic eligibility information, contact a *participating orthodontist* from the list, who is convenient to your location, to schedule an appointment. **ONLY THE ORTHODONTISTS ON THIS LIST ARE AUTHORIZED TO PROVIDE COVERED ORTHODONTIC SERVICES FOR YOU AND YOUR FAMILY MEMBERS.**

When you come in for your appointment, you will be required to show your Dental Net identification card and provide your orthodontist with the orthodontic eligibility information sent to you by us.

If you need to cancel or reschedule an appointment, please notify the orthodontist as far in advance as possible. **YOUR PARTICIPATING ORTHODONTIC OFFICE MAY CHARGE FOR A BROKEN APPOINT-**

MENT, OR AN APPOINTMENT NOT CANCELLED WITH AT LEAST 24 HOURS NOTICE. These charges are your responsibility and NOT ours.

WHAT'S COVERED

Your orthodontic benefits include the following services when provided by a *participating orthodontist*:

Orthodontic Consultation. Initial consultation to determine the extent of required orthodontic services.

Standard Orthodontic Treatment. Up to twenty-four (24) months of standard orthodontic services for correction of malocclusions, provided during your lifetime.

YOUR CO-PAYMENTS

Your *co-payments* for twenty-four months (24) of standard orthodontic services excluding records/retention fees are listed as follows:

Adults age 18 and over ..... **$ 1850.00**

Children through age 17..... **$ 1450.00**

The patient charge for orthodontics is determined from the SCHEDULE OF CO-PAYMENTS. Any down payments and amounts to be paid monthly by you based on this charge will be decided between you and the orthodontist.

LIMITATIONS AND EXCLUSIONS

In addition to the items listed under YOUR DENTAL BENEFITS: WHAT'S NOT COVERED AND LIMITED SERVICES, your orthodontic benefits are subject to the following limitations and exclusions:

ORTHODONTIC LIMITATIONS

Authorized Orthodontic Services. Orthodontic services must be received from a *participating orthodontic office* as specifically authorized and referred by us in writing.

Lifetime Maximum. Orthodontic treatment is limited to one full case (up to 24 months of standard orthodontic care) during your lifetime.

Loss of Coverage During Orthodontic Treatment. If your coverage under the *plan* ends, for any reason, while you are still receiving orthodontic treatment during the 24 month treatment period, you and NOT

Anthem will be responsible for the remainder of the cost for that treatment, at the *participating orthodontist's* customary and reasonable fee, prorated for the number of months of treatment remaining.

Orthodontic Consultation/Observation Fees. If treatment is not required or you choose not to start treatment after a diagnosis and consultation have been completed by the provider, you may be charged a consultation fee of **$30** in addition to diagnostic record fees.

Orthodontic Retention Phase of Care. Retention services include initial fabrication, placement, observation, and adjustments of passive retention appliances for a 12 month period. The retention services fee of **$250** is your responsibility and is payable at the beginning of the retention phase of treatment. Retention services fees are subject to review and modification on an annual basis.

Orthodontic Services in Excess of 24 Months of Active Care. You are required to pay the *participating orthodontist* up to **$55** per month for each additional month of standard active orthodontic treatment provided beyond the 24 month period, but before the retention phase of treatment begins.

ORTHODONTIC EXCLUSIONS

Changes in Treatment. Changes in treatment necessitated by an accident of any kind.

Myofunctional Therapy. Myofunctional therapy and related services. (Myofunctional therapy involves the use of muscle exercises as an adjunct to orthodontic mechanical correction of malocclusion.)

Orthodontic Records. Orthodontic records including, but not limited to, cephalometric tracings, photographs, study models and diagnostic radiographs.

Orthodontic Retreatment. The retreatment of a previously treated orthodontic case (whether treated under this coverage, at fee-for-service, or under another benefit plan) is not covered.

Orthodontic Services Provided Before or After the Term of Your Coverage. Treatment of orthodontic cases begun prior to your *effective date* or after termination of your coverage.

Orthodontic Treatment Incidental to Surgical Procedures. Orthodontic treatment in conjunction with oral surgical procedures including, but not limited to, orthognathic surgery.

Phase I Orthodontics/Orthopaedic/Orthodontic Treatment. Any Phase I treatment or orthopaedic/orthodontic treatment which may be deemed advantageous or necessary by the *participating orthodontist* prior to the 24 months of standard active treatment. Orthodontic treatment for malocclusions which, in the opinion of the *participating orthodontist* will not produce beneficial results.

Other Orthodontic Services. Services for braces, other orthodontic appliances, or orthodontic services, except as specifically stated in this Evidence of Coverage Form.

Replacement of Orthodontic Appliances. Replacement of lost or stolen orthodontic appliances or repair of orthodontic appliances broken due to your negligence.

Special Orthodontic Appliances. Special types of orthodontic appliances which are considered cosmetic including, but not limited to, lingual or “invisible” braces, sapphire or clear braces, or ceramic braces.

Surgical Procedures Incidental to Orthodontic Treatment. Surgical procedures incidental to orthodontic treatment including, but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate.

T.M.J. or Hormonal Imbalance Orthodontic Services. Treatment related to the joint of the jaw (temporomandibular joint, TMJ) and/or hormonal imbalance.

FOR YOUR INFORMATION

CLAIMS DISCLOSURE NOTICE REQUIRED BY ERISA

The certificate contains information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Plan Administrator or Anthem. In addition to this information, if this plan is subject to ERISA, ERISA applies some additional claim procedure rules. The additional rules required by ERISA are set forth below. To the extent that the ERISA claim procedure rules are more beneficial to you, they will apply in place of any similar claim procedure rules included in the certificate. This Claims Disclosure Notice Required By ERISA is not a part of your certificate.

Urgent Care. Anthem must notify you, within 72-hours after they receive your request for benefits, that they have it and what they determine your benefits to be. If your request for benefits does not contain all the necessary information, they must notify you within 24-hours after they get it and tell you what information is missing. Any notice to you by them will be orally, by telephone, or in writing by facsimile or other fast means. You have at least 48-hours to give them the additional information they need to process your request for benefits. You may give them the additional information they need orally, by telephone, or in writing by facsimile or other fast means.

If your request for benefits is denied in whole or in part, you will receive a notice of the denial within 72-hours after Anthem's receipt of the request for benefits, or 48 hours after receipt of all the information they need to process your request for benefits if the information is received within the time frame noted above. The notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision was based. You have 180-days to appeal their adverse benefit determination. You may appeal their decision orally, by telephone, or in writing by facsimile or other fast means. Within 72-hours after they receive your appeal, they must notify you of their decision, except as otherwise noted below. They will notify you orally, by telephone, or in writing by facsimile or other fast means. If your request for benefits is no longer considered urgent, it will be handled in the same manner as a Non-Urgent Care Pre-Service or Post-service appeal, depending upon the circumstances.

Non-Urgent Care Pre-Service (when care has not yet been received). Anthem must notify you within 15-days after they receive your request for benefits that they have it and what they have determined your benefits to

be. If they need more than 15-days to determine your benefits, due to reasons beyond their control, they must notify you within that 15-day period that they need more time to determine your benefits. But, in any case, even with an extension, they cannot take more than 30-days to determine your benefits. If you do not properly submit all the necessary information for your request for benefits to them, they must notify you, within 5-days after they get it and tell you what information is missing. You have 45-days to provide them with the information they need to process your request for benefits. The time period during which Anthem is waiting for receipt of the necessary information is not counted toward the time frame in which Anthem must make the benefit determination.

If your request for benefits is denied in whole or in part, you will receive a written notice of the denial within the time frame stated above, or after Anthem has all the information they need to process your request for benefits, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision is based. You have 180-days to appeal their adverse benefit determination. Your appeal must be in writing. Within 30-days after they receive your appeal, they must notify you of their decision about it. Their notice of their decision will be in writing.

Concurrent Care Decisions:

- **Reduction of Benefits –** If, after approving a request for benefits in connection with your illness or injury, Anthem decides to reduce or end the benefits they have approved for you, in whole or in part:
  - They must notify you sufficiently in advance of the reduction in benefits, or the end of benefits, to allow you the opportunity to appeal their decision before the reduction in benefits or end of benefits occurs. In their notice to you, Anthem must explain their reason for reducing or ending your benefits and the plan provisions upon which the decision was made.
  - To keep the benefits you already have approved, you must successfully appeal Anthem's decision to reduce or end those benefits. You must make your appeal to them at least 24-hours prior to the occurrence of the reduction or ending of benefits. If you appeal the decision to reduce or end your benefits when there is less than 24-hours to the occurrence of the reduction or ending of benefits, your appeal may be treated as if you were appealing

an urgent care denial of benefits (see the section “Urgent Care,” above), depending upon the circumstances of your condition.

- If Anthem receives your appeal for benefits at least 24-hours prior to the occurrence of the reduction or ending of benefits, they must notify you of their decision regarding your appeal within 24-hours of their receipt of it. If Anthem denies your appeal of their decision to reduce or end your benefits, in whole or in part, they must explain the reason for their denial of benefits and the plan provisions upon which the decision was made. You may further appeal the denial of benefits according to the rules for appeal of an urgent care denial of benefits (see the section “Urgent Care,” above).

- **Extension of Benefits –** If, while you are undergoing a course of treatment in connection with your illness or injury, for which benefits have been approved, you would like to request an extension of benefits for additional treatments:

  - You must make a request to Anthem for the additional benefits at least 24-hours prior to the end of the initial course of treatment that had been previously approved for benefits. If you request additional benefits when there is less than 24-hours until the end of the initially prescribed course of treatment, your request will be handled as if it was a new request for benefits and not an extension and, depending on the circumstances, it may be handled as an Urgent or Non-Urgent Care Pre-service request for benefits.

  - If Anthem receives your request for additional benefits at least 24-hours prior to the end of the initial course of treatment, previously approved for benefits, they must notify you of their decision regarding your request within 24-hours of their receipt of it if your request is for urgent care benefits. If Anthem denies your request for additional benefits, in whole or in part, they must explain the reason for their denial of benefits and the plan provisions upon which the decision was made. You may appeal the adverse benefit determination according to the rules for appeal for Urgent, Pre-Service or Post-Service adverse benefit determinations, depending upon the circumstances.

Non - Urgent Care Post-Service (reimbursement for cost of dental care). Anthem must notify you, within 30-days after they receive your claim for benefits, that they have it and what they determine your benefits

to be. If they need more than 30-days to determine your benefits, due to reasons beyond their control, they must notify you within that 30-day period that they need more time to determine your benefits. But, in any case, even with an extension, they cannot take more than 45-days to determine your benefits. If you do not submit all the necessary information for your claim to them, they must notify you, within 30-days after they get it and tell you what information is missing. You have 45-days to provide them with the information they need to process your claim. The time period during which Anthem is waiting for receipt of the necessary information is not counted toward the time frame in which Anthem must make the benefit determination.

If your claim is denied in whole or in part, you will receive a written notice of the adverse benefit determination within the time frame stated above, or after Anthem has all the information they need to process your claim, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision is based. You have 180-days to appeal their decision. Your appeal must be in writing. Within 60-days after they receive your appeal, they must notify you of their decision about it. Their notice to you or their decision will be in writing.

Note: You, your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits with Anthem and request a review of the denial. In connection with such a request:

- Documents pertinent to the administration of the Plan may be reviewed free of charge; and
- Issues outlining the basis of the appeal may be submitted.

You may have representation throughout the appeal and review procedure.

For the purposes of this provision, the meanings of the terms “Urgent Care,” “Non-Urgent Care Pre-Service,” and “Non - Urgent Care Post-Service,” used in this provision, have the meanings set forth by ERISA for a “claim involving urgent care,” “pre-service claim,” and “post-service claim,” respectively.

Get help in your language

Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version:

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (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
IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic
مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم1-888-254-2721 (TTY/TDD:711).

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese
重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi
مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید.(TTY/TDD:711)

Hindi
महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong
TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese
重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。1-888-254-2721 (TTY/TDD: 711)

Khmer
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ
យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។
អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសារបស់អ្នកផងដែរ។
ដើម្បីទទួលជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵਬੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੌਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog

MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่
หากท่านไม่สามารถอ่านจดหมายฉบับนี้
เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้
ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย
หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (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, Richmond, VA 23279 or by email to compliance.coordinator@anthem.com. 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.