Administered by
Community Insurance Company
1351 William H. Taft Road
Cincinnati, OH 45206

Dental Certificate of Coverage

Student Dental Plan

University of Cincinnati
Group Number L14525

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY

Important: If you opt to receive dental care services that are not covered benefits under this plan, a participating dental care provider may charge you his or her normal fee for such services. Prior to providing you with dental care services that are not covered benefits, the dental care provider will provide you with an estimated cost for each service.

Welcome to Anthem Blue Cross and Blue Shield (“Anthem”)!

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

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

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

Many words used in the Certificate have special meanings. These words appear in capitals and are defined for you. You should refer to the Definitions section for the best understanding of what is being stated.

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

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

Community Insurance Company
4241 Irwin Sampson Rd
Mason, OH 45040

How to Get Language Assistance

Anthem offers a Language Assistance Program to assist Members with limited English proficiency understand the dental coverage of this Plan at no additional cost, and in a timely manner. This program includes oral interpretation services and written translation for certain written materials vital to understanding Your dental coverage.

To request language assistance, please contact Customer Service by calling the phone number on Your Identification Card, to update Your language preference to receive future translated documents or to request interpretation assistance. Anthem also sends/receives TDD/TTY messages by using the National Relay Service through **711**. A special operator will get in touch with us to help with Your needs. For more information about the Language Assistance Program visit **www.anthem.com.**

Written materials available for translation include Grievance and Appeal letters, consent forms, claim denial letters, and explanations of benefits.

In addition, appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats are also available, free of charge and in a timely manner, when those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities.

Anthem Blue Cross Life and Health does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

For information on how to file a complaint concerning language assistance or discrimination, please see COMPLAINT AND APPEAL PROCEDURES later in this Certificate.

GET HELP IN YOUR LANGUAGE

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

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

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

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

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

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

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

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

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. **(TTY/TDD: 711)**

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

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

Oromo
Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda. Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (Member Services) waraqaa enyummaa kee irratti argamu irratti bilbili. **(TTY/TDD: 711)**

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

Romanian
Aveți dreptul să obțineți aceste informații și asistență în limba dvs. în mod gratuit. Pentru asistență, apelați numărul departamentului de servicii destinate membrilor de pe cardul dvs. de identificare. **(TTY/TDD: 711)**

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

Ukrainian
Ви маєте право безкоштовно отримати інформацію та допомогу своєю рідною мовою. По допомогу звертайтеся за номером служби підтримки учасників програми страхування, указаним на вашій ідентифікаційній картці. **(TTY/TDD: 711)**

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

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

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DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Non-Covered Services - Services or treatment not described within the section titled "Covered Services". While your dentist may prescribe Dental Services that are dentally or medically necessary, if the Dental Services are not listed within the Covered Services section, they are not covered nor a benefit of your plan.

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

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

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

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

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

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

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

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

Student - A student of the University who is the primary Member and is eligible for and has enrolled to receive benefits under the Group Dental Contract.

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

SUMMARY OF BENEFITS

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

Coverage Year	Contact Year - A 12-month period starting August 10
Dependent Age Limit	To the end of the month in which the child attains age 26.
Benefit Waiting Period	There are no benefit waiting periods.

DENTAL BENEFIT MAXIMUMS

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

Coverage Year Maximum $1000.00 per Member

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

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

DEDUCTIBLES

Deductible (combined for Participating and Non-Participating Dentist)

Participating Dentist	
Per Member	$50.00
Per Family	$150.00
Non-Participating Dentist	
Per Member	$50.00
Per Family	$150.00

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

Deductible. You are responsible for satisfying the Deductible before We pay for benefits. If 3 family Members satisfy their individual Deductible, the family Deductible will be met. Only charges that are considered a Maximum Allowed Amount will apply toward satisfaction of the Deductibles. For the Participating Dentist Deductible, only the Maximum Allowed Amount for the services of a Participating Dentist will be applied. For the Non-Participating Dentist Deductible, only the Maximum Allowed Amount for the services of a Non-Participating Dentist will be applied.

Dental Covered Services

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

	Participating Dentist	Non-Participating Dentist
Diagnostic and Preventive Services*	100%	100%
Basic Restorative Services	80%	80%
Non-Surgical Periodontal Services	80%	80%
Surgical Periodontal Services	50%	50%
Oral Surgery Services	50%	50%

*(Not subject to the Deductible)

ELIGIBILITY AND ENROLLMENT

Students

All students meeting the University's rules for coverage are eligible for coverage under this Evidence of Coverage. For specific information about the rules for coverage, please contact the University.

Note: A student may waive coverage under this plan only if he or she provides proof on or before the first day of the current term that he or she has other adequate health coverage that meets the University's requirements for coverage. See "Waiver of Coverage" below for more information.

Dependents

To be eligible for coverage to enroll as a Dependent, you must be enrolled by the Student using the enrollment process provided through the University and meet all Dependent eligibility criteria. The following may be enrolled as Dependents of the Student:

- The Student's legal spouse. A spouse does not include any person who is coverage as a Student or Domestic Partner.
- The Student's Domestic Partner, provided the Student and Domestic Partner have completed and filed a Declaration of Domestic Partnership pursuant to state law and the Domestic Partnership has not terminated. A Domestic Partner does not include any person who is covered as a Student or spouse. For purposes of this Plan, a Domestic Partner shall be treated the same as a spouse and a Domestic Partner's child, Adopted child or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.
- The Student's or the Student's spouse's or Domestic Partner's children under age twenty-six (26), including Newborn and Adopted children, Stepchildren, and any child for whom the Student has assumed a parent-child relationship.
- Children under age twenty-six (26) for whom the Student or the Student's spouse or Student's Domestic Partner is a legal guardian. Coverage of a Dependent child may be continued past the age limit of twenty-six (26) as an overage Dependent if he or she is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, and is chiefly dependent upon the Student for support and maintenance. To qualify as an overage Dependent, the Dependent's disability must start before the end of the period he or she would become ineligible for coverage. Anthem shall determine whether the Dependent meets these criteria before the Dependent attains the limiting age.
- Ninety (90) days before the Dependent reaches the age limit of twenty-six (26), we will issue a request for proof that the Dependent continues to meet the criteria for continued coverage.
- The Student must submit written proof of such dependency within sixty (60) days of receiving the request.
- Before the date the Dependent reaches the age limit of twenty-six (26), we will determine whether the Dependent meets the criteria for continued coverage.
- Two (2) years after receipt of the initial proof, we may require proof no more than annually of the continuing disability and dependency.

A new Student who enrolls in this benefit plan may also enroll an overage dependent who cannot work to support himself or herself by reason of intellectual or physical disability if the Dependent meets the criteria listed above as determined by Anthem. We may request a new Student to provide information regarding a Dependent with a continuing physically or mentally disabling injury, illness or condition at the time of enrollment and not more than annually thereafter for proof that the Dependent meets the criteria for continued coverage. The Student must submit written proof of such dependency within sixty (60) days of receiving the request.

We may require you to give proof of continued eligibility for any enrolled child. Your failure to give this information could result in termination of a child's coverage. To obtain coverage for children for whom you are the legal guardian, we may require you to give us a copy of any legal documents awarding guardianship of such child(ren) to you.

Types of Coverage

Your University offers the enrollment options listed below. After reviewing the available options, you may choose the option that best meets your needs. The options are as follows:

- Student only (also referred to as single coverage);
- Student and spouse, or Domestic Partner;
- Student and child(ren);
- Student and family

When You Can Enroll

Enrollment

Students are automatically enrolled if they are eligible.

To enroll Dependents, the Student must add the Dependents using the enrollment process provided through the University within 31 days from the eligibility date. We must receive notification of enrollment within 90 days. If any of these steps are not followed, coverage may be denied.

Special Enrollment Periods

If a Student or Dependent does not apply for coverage when they are first eligible, they may be able to enroll as a result of a qualifying event. Unless specifically stated otherwise, the Student or Dependent has sixty (60) calendar days from the date of a qualifying event to enroll.

Qualifying Events:

- Involuntary loss of Minimum Essential Coverage (loss of Minimum Essential Coverage includes loss of eligibility of coverage as a result of legal separation, divorce, cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment. Loss of eligibility does not include a loss due to the failure of the employee or Dependent to pay Premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan);
- Gain a Dependent or become a Dependent through marriage, Domestic Partnership, birth, adoption, placement for adoption or appointment of Domestic Partnership;
- Mandated to be covered as a Dependent pursuant to a valid state or federal court order;
- Release from incarceration;
- Health coverage issuer substantially violated material provision of health coverage contract'
- Access to new health benefit plans due to permanent move; and
- Member of the Reserve Forces of the U.S. military returning from active duty

Effective Dates for special enrollment periods:

- In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption; and
- In the case of marriage, Domestic Partnership or in the case where an Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after You complete the online enrollment process.

You must elect coverage and complete the online enrollment process within sixty (60) days.

Effective Dates for special enrollment due to loss of Minimum Essential Coverage apply when the loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

- Legal separation, dissolution of Domestic Partnership or divorce;
- Cessation of Dependent status, such as attaining the maximum age;
- Death of an employee;
- Termination of employment;
- Reduction in the number of hours of employment; or
- Any loss of eligibility for coverage after a period that is measured by reference to any of the following:
  - Individual who no longer resides, lives or works in the Plan's Service Area,
  - A situation in which Anthem no longer offers any benefits to the class of similarly situated individuals that includes the individual, and
  - Termination of employer contributions.

Eligible Students who involuntarily lose coverage under another group insurance plan are also eligible to purchase coverage under Group Dental Contract the day after prior coverage ends if the enrollment request is received by Anthem within 30 days from the loss of prior coverage.

There is no special enrollment for loss of Minimum Essential Coverage when the loss includes termination or loss due to:

- Failure to pay Premiums on a timely basis, including COBRA Premiums prior to expiration of COBRA coverage, or
- Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Late Enrollees

If the Student does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they will not be eligible to enroll until the next school term.

Enrolling Dependent Children

Newborn and Adopted Children

Newborn children are covered automatically from the moment of birth. Following the birth a child, you must submit an application / change form to the University within 31 days to add the newborn to your dental plan. Even if no additional Premium is required, you must still submit an application / change form to the University to add the newborn to your dental plan, to make sure we have accurate records and are able to cover your claims.

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption. The adopted child's Effective Date will be the date of the adoption or placement for adoption if you send us the completed application / change form within 31 days of the event.

Failure to submit a membership change form to the University to add a newborn or adopted child to your dental plan during the thirty-one (31) day period following birth or adoption will result in no coverage for the newborn or adopted child beyond the first thirty-one (31) days.

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage will be effective on the date the court granted legal custody or guardianship.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by applicable state or federal law, to enroll your child in this dental plan, and the child is otherwise eligible for coverage under the terms of the Group Dental Contract, we will permit the child to enroll at any time and will provide the benefits of this dental plan according to the applicable requirements of such order. However, a child's coverage will not extend beyond the age limit specified above.

Individuals not eligible for Dependent coverage

- Spouses of Dependent children are not eligible for coverage under this Plan.
- Children, including Newborns and Adopted Children, of Dependent children are not eligible for coverage under this Plan unless that child meets other coverage criteria established under State law.
- Temporary custody is not sufficient to establish eligibility under this dental plan.
- Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this dental plan unless required by the laws of this State.

Updating Coverage and/or Removing Dependents

You are required to notify the University of any changes that affect your eligibility or the eligibility of your Dependents for this dental plan. When any of the following occurs, contact the University and complete the appropriate forms:

- Changes in address;
- Marriage or divorce;
- Dissolution of a domestic partnership;
- Death of an enrolled Dependent (a different type of coverage may be necessary);
- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare;
- Dependent child reaching the Dependent Age Limit (see “Termination”);
- Enrolled Dependent child either becomes totally or permanently impaired, or is no longer impaired.

The University is required to notify us of these changes. We must be notified of any of these changes as soon as possible but no later than within sixty (60) days of the event. All notifications must be in writing and on approved forms. Failure to notify us of persons no longer eligible for services will not obligate us to pay for such services. Acceptance of premium for persons no longer eligible for services will not obligate us to pay for such services.

Contact Member Service at the telephone number listed on your ID Card or send your request to us.

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.

Statements and Forms

All students or applicants (including applicants to be covered as a Dependent) for coverage must complete and submit to the Group applications or other forms or statements that we may reasonably request.

Any rights to benefits under this dental plan are subject to the condition that all such information is true, correct, and complete. Any material misrepresentation by you may result in termination of coverage as provided in the “Termination” section. We will not use a statement made by you to void your coverage after that coverage has been in effect for two years. This does not apply, however, to fraudulent misstatements.

TERMINATION

Termination

Except as otherwise provided, your coverage may terminate in the following situations:

- When the Contract between the University and us terminates. It will be the University's responsibility to notify you of the termination of coverage.
- If the University no longer provides coverage for the class of Members to which you belong.
- If you choose to terminate your coverage.
- If you or your Dependents cease to meet the eligibility requirements of the Contract, subject to any applicable continuation requirements. If you cease to be eligible, the University and/or you must notify us immediately. The University and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- When the required Premiums are not paid, we may terminate your coverage and may also terminate the coverage of your Dependents upon first mailing a written Notice of Start of Grace Period to the University at least thirty (30) days, or if longer, the period required by federal law, prior to that termination. If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon our written notice to the University. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse us for the Maximum Allowed Amount for services received through such misuse.
- Coverage ends on the date the Student departs the country of assignment for his or her home country.
- Coverage ends on the date the Student ceases to meet visa requirements.

You will be notified in writing of the date your coverage ends by either us or the University.

Exception
Medical withdrawal or school authorized breaks. If you are an insured Student and the Premiums have been paid to us on your behalf, your coverage may continue for one semester during a medical withdrawal or school breaks approved by the University.

IMPORTANT: All of Your coverage will be terminated as of the date of termination, whether or not a specific condition was incurred prior to the termination date. Covered Services are eligible for payment only if your coverage is in effect at the time such services are provided.

Removal of Members
Upon written request through the University, you may cancel your coverage and/or your Dependent's coverage from the dental plan. If this happens, no benefits will be provided for Covered Services after the termination date.

DENTAL PROVIDERS AND CLAIMS PAYMENT

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

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

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

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

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

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

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

PROVIDER NETWORK STATUS

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

Participating Dentists

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

Non-Participating Dentists

Dentists who have NOT signed a written provider service agreement agreeing to service the program identified in this Certificate are considered Non-Participating Dentists. For Covered Services you receive from a Non-Participating Dentist, the Maximum Allowed Amount will be the lesser of the Dentist's actual charges or the amount determined by Us as follows:

An amount based on Our Non-Participating Dentist fee schedule, referred to as the Table of Allowances, which We have established in our discretion, and which we reserve the right to modify from time to time after considering one or more of the following: reimbursement amounts accepted by similar providers contracted with Us, and other industry cost, reimbursement and utilization data. The Table of Allowances may be different from the Maximum Allowed Amount reimbursed to Participating Dentists.

Unlike Participating Dentists, Non-Participating Dentists may send you a bill and collect for the amount of the Dentist's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allow Amount and the amount the Non-Participating Dentist charges. This amount may be significant. Choosing a Participating Dentist will likely result in lower out of pocket costs to you. Please call Member Services at (844) 729-1565 for help in finding a Participating Dentist or visit our website at www.anthem.com.

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

MEMBER COST SHARE

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

Payment of Benefits

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

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

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

Notice of Claim

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

The notice must be given to Us within 20 days of receiving the Covered Services, and must have the data We need to determine benefits. Failure to give Us notice within 20 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible.

Proof of Claim

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

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

Claims should be submitted to:

Anthem Blue Cross and Blue Shield
PO Box 1115
Minneapolis, MN 55440-1115
(844) 729-1565

Claim Forms

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

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

Member's Cooperation

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

Explanation of Benefits

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

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

COVERED SERVICES

Dental Utilization Review

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

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

Pretreatment Estimate
(Estimate of Benefits)

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

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

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

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

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

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

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

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

Retrospective Review

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

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

If you disagree with a utilization review decision and wish to file an Appeal or appeal a decision previously made, you will find details on how to do this in the CLAIM AND APPEAL PROCEDURES section of this certificate. You may also contact Member Services at the toll-free number on your Identification Card.

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

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

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

NOTE: Comprehensive oral evaluations will be benefited 1 time per dental office, subject to the 2 times per 12-month period limitation. Any additional comprehensive oral evaluations performed by the same dental office will be benefited as a periodic oral evaluation and will be subject to the 2 times per 12-month period limitation.

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

Radiographs (X-rays)

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

Dental Cleaning

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

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

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

Fluoride Treatment

- Topical application of fluoride and fluoride varnish - Covered 1 time per 12-month period for Dependent children through the age of 18.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered 1 time per 60-month period for permanent first and second molars of eligible Dependent children through the age of 18.

EXCLUSIONS - Coverage is NOT provided for:

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

Basic Restorative Services

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

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

Composite (white) Resin Restorations

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

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

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

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

Brush Biopsy - Covered 1 time every 12 months.

Consultations - Covered 1 time per 12 month period.

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

EXCLUSIONS - Coverage is NOT provided for:

1. Case presentation of detailed treatment plans and office visits, during and after regularly scheduled hours, when no other services are performed.
2. Athletic mouthguard, enamel microabrasion, and odontoplasty.
3. Tooth whitening agents and tooth bonding.
4. Placement or removal of sedative filling, base or liner used under a restoration.
5. Pulp vitality tests.
6. Diagnostic casts.
7. Secondary diagnostic tests in addition to the primary therapy.
8. Amalgam or composite restorations placed for preventive purposes.
9. Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.
10. Analgesia, analgesia agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care.

Periodontal Services (Gum & Bone Treatment)

NON-SURGICAL PERIODONTAL SERVICES

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

LIMITATION: Any combination of this procedure, and dental cleanings (see Diagnostic and Preventive section), Full Mouth Debridement and Scaling in the Presence of Moderate or Severe Gingival Inflammation is covered 2 times per 12-month period.

Scaling in the Presence of Moderate or Severe Gingival Inflammation - Scaling in the Presence of Moderate or Severe Gingival Inflammation is a procedure to remove plaque, tartar and calculus when there is moderate or severe gum inflammation.

LIMITATION: Any combination of this procedure, dental cleanings (see Diagnostic and Preventive section), Periodontal Maintenance and Full Mouth Debridement is covered 2 times per 12-month period.

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

- **Periodontal scaling & root planing** - Covered 1 time per 24 months if the tooth has a pocket depth of 4 millimeters or greater or if the tooth shows demonstrable radiographic evidence of bone loss.
- **Full mouth debridement**

LIMITATION: Any combination of this procedure, dental cleanings (see Diagnostic and Preventive section), Periodontal Maintenance and Scaling in the Presence of Moderate or Severe Gingival Inflammation is covered 1 time per lifetime.

Chemotherapeutic Agents - Covered 1 time per 12-month period.

SURGICAL PERIODONTAL SERVICES

All surgical periodontal services are covered on natural teeth only. Surgical periodontal services are denied when performed in conjunction with implants, extractions, ridge augmentation and periradicular surgery services.

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

- **Gingivectomy/gingivoplasty**
- **Gingival flap**
- **Osseous surgery**
- **Bone replacement graft**

LIMITATION: Any 1 or a combination of the above services may be performed 1 time per 36-month period. Complex surgical periodontal service is a benefit covered only if the pocket depth of the tooth is 5 millimeters or greater.

Apically positioned flap - Covered 1 time per tooth per 36-month period.

Guided tissue regeneration - Covered 1 time per tooth per 36-month period.

Pedicle soft tissue graft - Covered 1 time per tooth per 36-month period.

Free soft tissue graft - Covered 1 time per tooth per 36-month period.

Connective tissue graft - Covered 1 time per tooth per 36-month period.

Soft tissue allograft - Covered 1 time per tooth per 36-month period.

Distal/proximal wedge - Covered 1 time per tooth per 36-month period.

Crown lengthening

EXCLUSIONS – Coverage is NOT provided for:

1. Bacteriologic tests for determination of periodontal disease or pathologic agents.
2. Provisional splinting, temporary procedures or interim stabilization of teeth.
3. Analgesia, analgesic agents, anxiolysis, inhalation of nitrous oxide or therapeutic drug injections, drugs, or medicaments for non-surgical and surgical periodontal care, regardless of the method of administration.

Oral Surgery Services (Tooth, Tissue, or Bone Removal)

Basic Extractions

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

Complex Surgical Extractions

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

Other Complex Surgical Procedures - Complex Oral Surgery includes surgical procedures that involve flap development with the removal and replacement of diseased hard and soft tissues of the oral cavity.

- Oroantral fistula closure
- Tooth reimplantation – accidentally evulsed or displaced tooth
- Mobilization of erupted or malpositioned tooth to aid eruption
- Biopsy of oral tissue
- Transseptal fiberotomy
- Alveoloplasty
- Vestibuloplasty
- Excision of lesion or tumor
- Removal of nonodontogenic or odotogenic cyst or tumor
- Removal of exostosis-per site
- Partial ostectomy
- Incision & drainage of abscess
- Surgical reduction of osseous tuberosity
- Surgical reduction of fiberous tuberosity
- Exfoliative cytological sample collection

Frenulectomy (Frenectomy or Frenotomy)

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

LIMITATIONS

1. Reconstructive Surgery benefits shall be provided for reconstructive surgery when such Dental Procedures are incidental to or follows surgery resulting from injury, illness or other diseases of the involved part, or when such Dental Procedure is performed on a covered Dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, however that such procedures are dental reconstructive surgical procedures.

EXCLUSIONS - Coverage is NOT provided for:

1. Intravenous conscious sedation, IV sedation and general anesthesia when performed with non-surgical dental care.
2. Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration.
3. Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
4. Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants.
5. Inpatient or outpatient hospital expenses.
6. Implant maintenance or repair to an implant or implant abutment.

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

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

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

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

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

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

Enhanced benefit for Members who are enrolled in the Anthem Care Management program. Enhanced dental benefits are available for any member enrolled in the Anthem Care Management program who is in active management with an Anthem Care Manager for the following conditions:

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

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

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

EXCLUSIONS

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

Coverage is NOT provided for:

a) Dental Services that have been paid under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. Benefits under this Certificate will not be reduced or denied because Dental Services are rendered to a Subscriber or Dependent who is eligible for or receiving Medical Assistance.

b) Dental Services or health care services not specifically listed in the Covered Services section of this Certificate (including any hospital charges, prescription drug charges and Dental Services or supplies that do not have an American Dental Association Dental Procedure Code).

c) Services provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist.

d) Dental Services completed prior to the date the Member became eligible for coverage.

e) Services of anesthesiologists.

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

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

h) Dental Services performed other than by a licensed Dentist, licensed physician, his or her employees.

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

j) Artificial material implanted or grafted into or onto bone or soft tissue, including implant services and associated fixtures, or surgical removal of implants.

k) Tooth whitening agents and tooth bonding.

l) Orthodontic treatment services, unless specified in this Certificate as a covered Dental Service benefit.

m) Case presentations of detailed treatment plans, office visits during and after regularly scheduled hours, when no other services are performed.

n) A permanent appliance or restoration (such as a partial, denture, bridge or crown) that has not been permanently cemented.

o) Athletic mouth guards, enamel microabrasion and odontoplasty.

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

q) Bacteriologic tests.

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

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

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

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

v) Provisional splinting, temporary procedures or interim stabilization.

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

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

y) Oral hygiene instruction, including guidance regarding home care. Some examples of oral hygiene instructions includes instructions or guidance on tooth brushing technique, flossing, and/or use of special oral hygiene aids.

z) Any charges which exceed the Maximum Allowed Amount.

aa) Implant maintenance or repair to an implant or implant abutment.

bb) Pulp vitality tests

cc) Secondary diagnostic tests in addition to the primary therapy.

dd) Diagnostic casts.

ee) Incomplete root canals.

ff) Cone beam images.

gg) Anatomical crown exposure.

hh) Temporary anchorage devices.

ii) Amalgam or composite restorations placed for preventive or cosmetic purposes.

jj) Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.

kk) Orthodontic services.

ll) Endodontic Services.

mm) Major Restorative Services.

nn) Prosthodontic Services.

Limitations

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

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

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

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

Optional Treatment Plans

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

GENERAL PROVISIONS

Form or Content of Certificate

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

Relationship of Parties (Plan - Participating Dentists)

Providers are independent contractors. Anthem is not responsible for any claim for damages or injuries suffered by the Member while receiving care from any Provider.

Not Liable for Provider Acts or Omissions

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

Identification Card

We will give an Identification Card to each Member enrolled in the dental plan. When you get care, you must show your Identification Card. Only a Member who has paid the Premiums for this dental plan has the right to services or benefits under this Certificate. If anyone gets services or benefits to which they are not entitled to under the terms of this Certificate, he/she must pay for the actual cost of the services.

Circumstances Beyond the Control of the Plan

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

Employer Premiums

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

Extension of Benefits

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

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

3. Root canal therapy, for which the pulp chamber was opened prior to the benefit termination date.

Extension of Benefits will not apply if the Group Dental Contract terminates.

Coordination of Benefits (COB)

This Coordination of Benefits ("COB") provision applies when a person has dental care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan.

The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

Definitions

- A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

    1. Plan includes: group and non-group insurance contracts, health insuring corporation ("HIC") contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

    2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

- This plan means, in a COB provision, the part of the contract providing the dental care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing dental care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

- The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has dental care coverage under more than one Plan. When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

- Allowable expense is a dental care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an Allowable expense.

  The following are examples of expenses that are not Allowable expenses:

  1. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

  2. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

  3. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

  4. The amount of any benefit reduction by the Primary plan because a Member has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of Dental Services, and preferred provider arrangements.

- Closed panel plan is a Plan that provides dental care benefits to Members primarily in the form of services through a panel of providers which have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

- Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
- However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), We will follow the rules of that plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's dental care expenses or dental care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's dental care expenses or dental care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental care expenses or dental care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's dental care expenses or dental care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial parent;
- The Plan covering the spouse of the Custodial parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

Effect On The Benefits Of This Plan

- When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other dental care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other dental care coverage.

- If a Member is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

Right to Receive and Release Needed Information

Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. We may get the facts We need from them or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give Us any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. We will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Us is more than We should have paid under this COB provision, We may recover the excess from one or more of the persons We paid or for whom We had paid, or any other person or organization that may be responsible for the benefits or services provided for the Member. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes

If you believe that We have not paid a claim properly, you should first attempt to resolve the problem by contacting Us. Follow the steps described in the "Complaint and Appeals Procedures" section of the Certificate. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department’s website at *http://insurance.ohio.gov*.

Relationship of Parties (University-Member-Plan)

The University is responsible for passing information to you. For example, if we give notice to the University, it is the University’s responsibility to pass that information to you. The University is also responsible for passing eligibility data to us in a timely manner. If the University does not give us timely enrollment and termination information, we are not responsible for the payment of Covered Services for Members.

Conformity with Law

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

Modifications

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

Physical Examination and Autopsy

At our expense, we have the right and opportunity to examine any insured person claiming benefits when and as often as reasonably necessary while a claim is pending.

Legal Action

No attempt to recover on the dental plan the University has purchased through legal or equity action may be made until at least 60 days after the written proof of loss has been furnished as required by state law. No such action may be started later than three years from the time written proof of loss is required to be furnished.

Reservation of Discretionary Authority

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

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

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

Incontestability

All statements made by a Member will, in the absence of fraud, be deemed representations and not warranties. No such statement will be used in defense of any misstatement of omission of information made on the Member's application form or on any other materials on which Anthem relied to issue coverage. After coverage for a Member has been in force for two years during the Member's lifetime, Anthem does not have the right to contest that coverage, except for fraud or non-payment of Premiums.

CLAIM AND APPEAL PROCEDURES

All claims should be submitted within 12 months of the date of service. An initial benefit determination on your claim will be made within 30 days after receipt of your claim. You will receive written notification of this benefit determination. The 30-day period may be extended for an additional 15 days if the claim determination is delayed for reasons beyond our control. In that case, we will notify you prior to the expiration of the initial 30-day period of the circumstances requiring an extension and the date by which we expect to render a decision. If the extension is necessary to obtain additional information from you, the notice will describe the specific information we need, and you will have 45 days from the receipt of the notice to provide the information. Without complete information, your claim will be denied.

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

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

Anthem Blue Cross and Blue Shield
Attention: Appeals Unit
PO Box 1122
Minneapolis, MN 55440-1122

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

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

Authorized Representative
You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or an Appeal. However, no authorization is required for your treating dentist to make a claim or Appeal on your behalf. The authorization form must be in writing, signed by you, and include all the information required in our Authorized Representative form. This form is available at our web site or by calling Member Services at (844) 729-1565. You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.