Anthem BlueCross BlueShield

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City of Milwaukee

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Dental benefits underwritten by Compcare Health Services Insurance Corporation

Your Dental Certificate

Dental Certificate of Coverage

WI Dentacare 100

BENEFIT HANDBOOK

We settle claims based upon varying methodologies, which may be less than the provider's billed charge. Please see page D-28 of this Booklet for a more detailed explanation.

IMPORTANT NOTICE REGARDING STATEMENTS IN THE ENROLLMENT FORM FOR YOUR INSURANCE

Please review the copy of the enrollment form you completed when applying for coverage. Omissions or misstatements in the enrollment form could cause an otherwise valid claim to be denied. Carefully check the enrollment form and write to Us within ten (10) days if any information in the form is incorrect or if any information is missing.

ANTHEM BLUE CROSS AND BLUE SHIELD
P.O. Box 659444
San Antonio, TX 78265-9444
1-866-589-0582

Please Direct Correspondence, Claims & Grievances To:
ANTHEM BLUE CROSS AND BLUE SHIELD
P.O. Box 659471
San Antonio, TX 78265-9471

COMPCARE HEALTH SERVICES INSURANCE CORPORATION ("COMPCARE")
dba ANTHEM BLUE CROSS AND BLUE SHIELD
N17 W24340 Riverwood Drive
Waukesha, WI 53188

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Contents

1 GENERAL INFORMATION

IDENTIFICATION (ID) CARDS

You will receive a DENTACARE ID card. It ends most red tape and claim procedures. Show your card to your dentist when requesting services.

CUSTOMER SERVICE INQUIRIES

If you have questions regarding your coverage, please call the appropriate Customer Service location listed below.

ANTHEM BLUE CROSS AND BLUE SHIELD
P.O. Box 659444
San Antonio, TX 78265-9444
1-866-589-0582

SELECTING YOUR DENTIST

Regardless of any previous dental relationship You may have had, You have now elected to obtain dental care through the Dentacare Center and its staff. A professional staff of Dentists, hygienists, and assistants will take care of Your dental needs at Your Center. With the help of Your Dentacare Center staff, You will choose a personal Dentist for Your dental care. After a preliminary examination, x-rays and diagnosis, You should continue to see the same Dentist for Your dental care. Or, if You wish, You may choose another Dentist from those participating at Your Center. Your selection may be accepted or rejected depending on whether Your chosen Dentist is available for new patients and/or is a participating Dentist. If at any time you waive your right to make a selection, We may transfer Your care to a Dentacare Dentist or Dental Center of our choosing.

Under their contract with Us, the dental professionals and dental facilities may receive financial incentives to provide covered services in the most cost-efficient manner consistent with sound dental practice and without compromising the patient's health.

MAKING AN APPOINTMENT

DENTACARE Services are offered at Your convenience, whenever possible. When You wish to see Your DENTACARE Dentist, call Your center for an appointment. It is important always to call first for an appointment in order to get more efficient service.

If You are unable to keep an appointment, please call Your Dentist's office at least 24 hours in advance or as soon as possible before the scheduled appointment time. Failure to do so may result in a charge to You for the missed appointment. Should You need immediate advice or emergency care, a DENTACARE Dentist is on call 24 hours a day.

COVERAGE PROVIDED

This booklet is not the Contract. If there is a conflict between the Contract and this booklet, the Contract controls. Subject to the limitations, exclusions and conditions of the Contract, You are entitled to the Dental Services and Emergency Services described in this booklet.

2 DEFINITIONS

As used in this booklet, the following terms are defined as:

BENEFITS means Dental Service and Emergency Service performed, to the extent specified herein.

CO-INSURANCE means a portion of the Maximum Allowed Amount for Dental Services for which You are responsible. Your Coinsurance will not be reduced by refunds, rebates, or any other form of negotiated post-payment adjustments.

CONTRACT - the written agreement We have with the Group. The contract defines the benefits, terms and conditions of coverage.

DENTAL GROUP - the Dental Center you are enrolled in as shown on Your identification card.

DENTAL SERVICE - those professional services of Dentists, and the professional and para-dental personnel engaged by the Dental Group. This includes diagnostic, therapeutic and preventive services. Dental Services must be documented in provider records.

DENTIST - a licensed Doctor of Dental Surgery, a licensed Doctor of Medical Dentistry, or equivalent, as recognized by the American Dental Association. This includes any other professional practitioner authorized by law to practice dentistry at the time and place Dental Services are performed.

DEPENDENT - a Participant other than You. Dependent is described in Dependent Eligibility.

EFFECTIVE DATE - the date on which a Participant's coverage becomes effective.

EMERGENCY SERVICE - Dental Service which is needed unexpectedly and immediately due to accidental injury or emergency illness while the Participant is outside the Service Area. It does not include elective care or care which the Participant could reasonably have foreseen before leaving the area.

EMPLOYEE - means a member of the Group who:

1. Meets the Group's eligibility requirements for fringe benefits;
2. Meets the Contract's eligibility requirements;
3. Has applied and been accepted by Us for coverage under this Contract; and
4. Has caused premium payment to be made on his behalf.

EXPEDITED GRIEVANCE - means a Grievance which requires immediate consideration and involves any of the following circumstances:

1. Serious jeopardy to the life or health of the Member or the ability of the Member to regain maximum function;
2. A situation where, in the opinion of a Dentist with knowledge of the Member's condition, the Member would be subjected to severe pain that cannot be adequately managed without the service or treatment that is the subject of the grievance.
3. It is determined by a Dentist with knowledge of the Member's dental condition that an Expedited Grievance exists.

EXPERIMENTAL/INVESTIGATIONAL - means procedures not yet recognized by the American Dental Association as indicated with a specific procedure code designation, or procedures which are not widely accepted as proven and effective procedures within the organized dental community.

Decisions made to deny or limit dental treatment based on an Experimental/Investigational basis are made by a licensed Dentist or any other professional practitioner licensed to practice dentistry. In the event You disagree with this or any decision you have the right to file a written Grievance. You will find details on how to do this in the General Provisions section of this booklet. You may also contact Our customer service number on your ID card.

A request for a pre-treatment determination may be submitted in writing to Us. If prior written approval for a treatment, or service is provided, benefits will be paid if the Member's coverage is in force and if the approval has not expired at the time such treatment, or service is provided.

GRIEVANCE - means a written complaint that You, or someone on Your behalf, files with Us. The Grievance may involve Your dissatisfaction with Our administration or claims practices, the provision of services, denial of services, or limitations based on Experimental / Investigational treatment.

GROUP - the employer, organization, or Association through which You have this coverage.

GROUP DENTIST - A Dentist associated with or engaged by the Dental Group.

LABORATORY CHARGES - Charges for an indirect restoration, or a prosthetic device. It includes charges for repairs to those items.

MAXIMUM ALLOWED AMOUNT - the maximum amount of reimbursement We will allow for Dental Services under the plan, as outlined in the "How Maximum Allowed Amount is Determined" section of this Booklet.

MEDICALLY NECESSARY (MEDICAL NECESSITY) - Medically Necessary procedures, services, or treatments are those that 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 that will produce a professionally satisfactory result.

OPEN ENROLLMENT PERIOD - an Enrollment Period when any eligible Employee or Dependent of the Group may apply for this coverage and existing Participants can change Dental Groups.

PARTICIPANT - means the Employee or any of his Dependents whom the Employee and Group have certified to Us as eligible for benefits hereunder and for whom the appropriate premiums have been paid.

QUALIFYING EVENT - Qualifying Events include the following:

1. Marriage or divorce.
2. Death of a spouse or child.
3. Birth or adoption of a child.
4. Termination or commencement of employment of Employee's spouse.
5. Change in employment status of either the eligible group Employee or his spouse from full-time to part-time or vice-versa.
6. An unpaid leave of absence (does not include medical leave of absence) by either the eligible group Employee or his spouse.
7. A significant change in the benefit coverage or premium contribution of the eligible group Employee or his spouse attributable to the spouse's employment.

SERVICE AREA - the area within fifty (50) miles of the Dental Group location.

WE, US (OUR) - COMPCARE HEALTH SERVICES INSURANCE CORPORATION dba Anthem Blue Cross and Blue Shield, which provides benefits to Members for the Covered Services described in this Booklet

YOU (YOUR) - an eligible person affiliated with the Group, who has enrolled for coverage under the Contract. In the description of Dental Services, "You (Your)" includes your Dependent Participants.

3 ELIGIBILITY

Unless We have approved different eligibility terms for Your Group, to be eligible, you must: (1) actively perform the duties of your principal occupation; (2) satisfy any probationary period that applies to you; and (3) be eligible for all the fringe benefits which apply to the class of Employees to which you belong.

DEPENDENTS

Dependent Coverage covers only those dependents which you listed on your individual application for coverage. It is important that you accurately and promptly report all your dependents to Us. You should also report to your Group any changes such as births, or additions of step-children within thirty-one (31) days of the event or adoptions within sixty (60) days of the event. Your Group will then notify Us of the changes.

If you have Dependent Coverage, your spouse and dependent children are entitled to the same benefits as you. Your spouse is the person to whom you are lawfully married. Your dependent children are the lawful children of you and/or your spouse. Dependent children are covered from birth through the calendar year they become 26 years old.

If one of your unmarried children is totally and permanently disabled before the end of the calendar year the child reaches the limiting age, and dependent on you for support and maintenance within the meaning of the Internal Revenue Code of the United States, your Plan will continue providing coverage to the child for as long as the child remains disabled and you remain a Participant of the plan. Totally and permanently disabled means he or she is not capable of self-sustaining employment due to mental retardation or physical handicap. You must claim disability status within thirty-one (31) days of the end of that calendar year. We may require proof of disability as often as necessary.

You may also continue coverage if your unmarried child is called to active duty in the National Guard or in a reserve component of the United States armed forces prior to age 27 and is currently a full-time student, regardless of age. The Dependent child cannot be eligible for coverage under his/her employer's group health plan unless the premium for that coverage is greater than the premium charged for a Dependent under this Booklet. Coverage will end when the child ceases to be a full-time student, marries, or becomes eligible for a group health plan for which the premium is less than the premium charged a Dependent under this Booklet. We may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

If your spouse or dependent children lose their eligibility for this plan, they may apply for continuation coverage.

COVERAGE OF DEPENDENT STUDENTS ON MEDICAL LEAVE

The information below applies to Dependent students who were called to active duty in the National Guard or in a reserve component of the United States armed forces prior to age 27 and have now returned to school on a full-time basis.

If, while covered under this Booklet, a Dependent student needs to reduce his/her course load or leave school due to a Medically Necessary leave of absence, the Dependent student may be eligible to continue coverage under this Booklet.

We may require documentation of the Medical Necessity of the leave of absence from the Dependent's attending Physician. The date on which the Dependent ceases to be a full-time student due to the Medically Necessary leave of absence shall be the date on which the continuation of coverage begins.

Coverage will continue until any of the following occurs:

1) We are advised that the Dependent does not intend to return to school full time.

2) The Dependent becomes employed full time.

3) The Dependent obtains other health care coverage.

4) The Dependent marries and is eligible for coverage under his or her spouse's health care coverage.

5) Coverage of the Member through whom the person has Dependent coverage under this Booklet is discontinued or not renewed.

6) One year has elapsed since the Dependent's continuation of coverage began and the Dependent has not returned to school full time.

APPLICATION

You can apply for coverage at the following times:

1. Within thirty-one (31) days of initial eligibility, or
2. Within thirty-one (31) days of Open Enrollment, or
3. Within thirty-one (31) days of a Qualifying Event.
4. Within 60 days after Medicaid coverage ends.

If you fail to apply within the above stated timeframes, coverage hereunder shall not be available until the next Open Enrollment Period.

BADGERCARE

If the Wisconsin Department of Health and Family Services agrees to purchase coverage under this Booklet for you in lieu of enrolling you in the Medical Assistance Program (under s. 49.472, Wis. Stat.), Badger Care (under s. 49.665, Wis. Stat.), or BadgerCare Plus (under s. 49.471, Wis. Stat.), you will have 60 days from the date of that determination to apply for this coverage. If we receive your completed application within 60 days, We will enroll you on the first of the month following Our receipt of the application.

EFFECTIVE DATE

Your effective date follows both your completion of any probationary period and Our approval of your application. In no event shall your Effective Date be prior to your completion of the probationary period, if any.

If you apply for your coverage and your dependent's coverage at the same time, you and your dependent will have the same effective date.

A dependent's effective date cannot be before your effective date.

If you marry after your coverage is effective, you should apply for Dependent Coverage within thirty-one (31) days of your marriage. If you do, your Dependent Coverage becomes effective on the marriage date.

Coverage for a newborn child begins on the date of birth. If additional payment is required for the newborn, it must be paid within sixty (60) days of the birth; if the payment is not paid within that time, coverage for the newborn ends sixty (60) days after birth. Within one year of the birth, you may reinstate the newborn's coverage by paying all past due premiums plus interest at the rate of five and one-half percent ($5\frac{1}{2}\%$) per year.

If you have Dependent Coverage and (1) you adopt a child, or (2) you have a child placed with you for adoption, or (3) you are named the legal guardian for a child, the effective date of coverage for the child is the earlier of:

1. the date of the final court order granting adoption; or
2. the date the child is placed with you or your dependent for adoption.

You are required to notify Us of this and pay the additional premium, if any, within sixty (60) days of the adoption, placement, or appointment.

In all other circumstances, if you apply for Dependent Coverage after your Effective Date, your Dependents shall not be entitled to benefits unless your application for a family-type

membership has been accepted and Dependent Coverage is in effect. In the event you do not apply for Dependent's coverage with thirty-one (31) days after such Dependents first become eligible for coverage, coverage hereunder shall not be available until the next Open Enrollment Period.

You are not covered by your plan until your Effective Date. We will notify you of your Effective Date when sending your Identification Card.

Unless you or your dependent are totally disabled:

You must be actively at work on the Effective Date, if not the Effective Date is the day you return to active work. A day of vacation or holiday is considered active work for purposes of the Effective Date if you are capable of active work on this date.

CESSATION OF ELIGIBILITY

Except as provided herein, your eligibility for benefits under this Contract ceases on the last day of the month in which you no longer meets the eligibility requirements set forth above.

INDIVIDUAL REINSTATEMENTS

If coverage ends because Your employment terminates, Your coverage may be reinstated on Your return to full-time employment. If You return within ninety (90) days of the termination date, coverage is effective on the date of return. The benefits We reinstate are the benefits that would have been available had You been continuously insured. You must pay any required premium.

If You return to full-time employment more than ninety (90) days after Your termination date, We consider You a new Employee.

If you return to full-time employment upon the completion of an FMLA leave period and you elect to have coverage reinstated or the Group requires your coverage be reinstated, coverage will be reinstated on the date you return from FMLA leave. The benefits We reinstate are the benefits that you and your Dependents would have received if coverage had been continuous.

Following a military leave, if you return or request re-employment within the statutory period, coverage will be reinstated on the date you return. If you had converted your coverage, your conversion policy ends on the day We reinstate this coverage.

COURT-ORDERED COVERAGE

If a court orders a Participant to provide coverage for dental expenses for a child of the Participant and the Participant is eligible for Family Coverage under this Contract, We:

1. Provide Family Coverage under the Contract for the Participant child, if eligible for coverage, without regard to any enrollment period restrictions that may apply under the Contract;

2. Provide Family Coverage under the Contract for the Participant's child, if eligible for coverage, upon application by the Participant, the child's other parent, or the Department of Health and Family Services or the county designee under s. 59.07 (97); and

3. After the child is covered under the Contract, and as long as the Participant is eligible for Family Coverage under the Contract, continue to provide coverage for the child unless We receive satisfactory written evidence that the court order is no longer in effect or that the child has coverage under another group policy or individual policy that provides comparable dental coverage.

If We provide coverage under a Contract for a child of a Participant who is not the custodial parent of the child, We shall do all of the following:

1. Provide to the custodial parent of the child information related to the child's enrollment;

2. Permit the custodial parent of the child, a dental provider that provides services to the child, or the Department of Health and Family Services to submit claims for Benefits without the approval of the parent who is the Participant; and
3. Pay claims directly to the dental provider, the custodial parent of the child, or the Department of Health and Family Services as appropriate.

4 DENTAL UTILIZATION REVIEW

Dental utilization review is a process designed to promote the delivery of cost-effective dental care by encouraging the use of clinically recognized and proven procedures. Dental utilization review is included in Your dental benefits to encourage You to utilize Your dental benefits in a cost-effective and clinically recognized manner. Your right to benefits for Dental Services provided under this plan is subject to certain policies, guidelines and limitations, including, but not limited to, Our coverage 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 the standards of care for dental practice and state-specific regulations. The purpose of dental coverage guidelines is to assist in the interpretation of Medical Necessity. In order to be covered expenses or services under this plan, expenses must meet the Medically Necessary requirements.

Pre-Treatment Review

You may have a pre-treatment review done before you receive benefits. Pre-treatment review is not a prior authorization for services but is a system that allows You and Your Dentist to know, in advance, what the estimated benefits payable would be under this plan for a proposed course of treatment. The actual benefits you receive under the plan will be determined once a claim for services has been received and may vary from the estimated benefits based upon the actual services received as well as the benefit coverage in effect on the date(s) of services.

Under pre-treatment review, Your Dentist prepares a request for a pre-treatment benefit estimation form, and submits this form to us before any treatment begins. The pre-treatment benefit estimation form should: (a) list the recommended dental services; and (b) show the charge for each dental service. We will review this request and send a copy of Our estimated benefits to You and Your Dentist. We may request supporting pre-operative x-rays or other diagnostic records in connection with the pre-treatment review. A pre-treatment review is recommended if the proposed course of treatment is expected to involve charges of **$350 or more**.

If the course of treatment is not reviewed before treatment is received, it will be reviewed when the claim is submitted to us for payment.

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 Dentist 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.

If You disagree with a utilization review decision and wish to file a grievance, or appeal a decision previously made You will find details on how to do this in the General Provisions section

of this booklet. You may also contact Our customer service number on your ID 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. A more detailed description of the decision making timeframes are set forth in Our utilization review guide. This guide is available by calling customer service at 800-627-0004.

5 COVERED SERVICES

You are entitled to the Dental Services described in this booklet. The Dental Services must begin on or after Your Effective Date, be Medically Necessary, be furnished according to a Dentist's order, and not be performed primarily for cosmetic or esthetic purposes. Benefits are subject to the terms and conditions of the Contract.

Certain Dental Services are subject to Co-insurance which are specified in this Article. We calculate Co-insurance based upon Our Maximum Allowed Amount.

WHILE UNDER THE CARE OF GROUP DENTISTS

A. Diagnostic

1. These dental x-rays: intraoral complete series and periapical films, intraoral occlusal films, bite-wing x-rays, panoramic films, and cephalometric films.
2. Routine oral examinations and Adult or Pediatric Prophylaxis.
   a. Adult Prophylaxis means the scaling and cleaning of teeth of Participants thirteen (13) years of age and older.
   b. Pediatric Prophylaxis means the scaling and cleaning of teeth of Dependents twelve (12) years of age and under.

   Periodontal scaling and root planing is a separate procedure from prophylaxis. Please refer to the booklet section describing periodontal benefits.
3. Pulp vitality tests.
4. Diagnostic casts and photographs for orthodontic purposes only.

B. Preventive

1. Topical Fluoride Treatment.
2. Oral hygiene, plaque control, and dietary instruction.
3. Initial placement of sealants on posterior permanent teeth within two (2) years of their eruption. Replacement of sealants is covered only if three (3) years have elapsed since the last placement.
4. Space maintainers that replace prematurely lost primary teeth.

C. Ancillary

1. Intravenous sedation when Medically Necessary. If intravenous sedation is needed because of a medical condition, Your Group Dentist will require a doctor's statement of Medical Necessity. We cover intravenous sedation needed because of mental retardation, but not because of patient anxiety.
2. Emergency palliative treatment (relief of pain).
3. Emergency denture repairs and adjustments.
4. Analgesia (e.g. nitrous oxide-oxygen sedation).

D. Restorative

1. Direct Restorations (Fillings)
   Amalgam, silicate, resin, acrylic, synthetic porcelain, and composite filling restorations of diseased or broken teeth.
2. Indirect Restorations (Cast Restorations).
   Inlays, onlays or crowns to restore diseased or broken teeth, if the tooth, as a result of extensive caries or fracture, cannot be restored by direct restoration. Except for temporary or stainless steel crowns, replacement of crowns is covered only if at least five (5) years have elapsed since the insertion of the existing crown.

You are not liable for any Laboratory Charges.

Metal, Baked Porcelain Restorations, Inlays, Crowns, and Jackets: If Your tooth can be restored with amalgam, silicate, resin, acrylic, synthetic porcelain, composite or plastic, these materials will be used. This decision is made by Your Group Dentist.

Posterior Restoration: Benefits are limited to the procedures that are Medically Necessary to achieve restoration. This means that if an amalgam restoration would give a satisfactory result, but You and Your Group Dentist choose a resin restoration, the balance of the cost for the resin restoration is Your responsibility.

Mouth Rehabilitation: If You and Your Group Dentist choose a course of Mouth Rehabilitation, only the procedures that are Medically Necessary to eliminate oral disease and replace missing teeth are covered. The rest of the charges are Your responsibility.

E. Oral Surgery

Provides benefits for the following Oral Surgery and simple extractions.

1. Routine extractions.
2. Surgical extractions.
3. Apicoectomy - Excision of Apex of tooth root.
4. Removal of exostosis of the maxilla or mandible.
5. Incision and drainage of abscess - intraoral soft tissue.
6. Gingivectomy or Gingivoplasty - Excision of loose gum tissue to eliminate infection.
7. Gingival curettage.
8. Gingival flap procedure, including root planing.
9. Osseous surgery.
10. Alveoloplasty - The leveling of structures supporting teeth or the purpose of fitting dentures.
11. Frenectomy - Incision of any mid-line fold of tissue between the jaws and lips and between the lower jaw and tongue.
12. Removal of retained (residual) root.
13. Removal of exposed roots.
14. Surgical exposure of impacted or unerrupted teeth.

F. Endodontics

Pulpal and root canal therapy.

G. Periodontics

Surgical treatment is limited to the oral surgery procedures and benefits listed in the Oral Surgery Section.

Covered non-surgical procedures include periodontal scaling and root planing, periodontal scaling performed in the presence of gingival inflammation, periodontal maintenance procedures following active therapy, and other non-surgical periodontal procedures except as specifically excluded in General Exclusions.

H. Prosthodontics

1. Initial insertion of fixed partial denture (including inlays and crowns as abutments).
2. Initial insertion of partial or full removable dentures (including any adjustments). Precision attachments are covered only when they replace an existing precision attachment.

3. Replacement of an existing removable partial, full denture or fixed bridge by a new removable partial, full denture or a fixed bridge. The addition of teeth to an existing removable partial denture or to a bridge. Replacement of prosthodontic appliances is covered only if at least five (5) years have elapsed since the insertion of the existing appliance.
4. Stress breakers are covered only if they replace existing stress breakers.

Partial or Complete Dentures: Benefits are limited to the procedures that are Medically Necessary to eliminate oral disease and restore missing teeth. This means that if standard procedures and materials would give a satisfactory result, but You and Your Group Dentist choose specialized techniques, the balance of the cost for the specialized technique is Your responsibility.

You are not liable for any Laboratory Charges.

I. Orthodontics

Orthodontic diagnostic procedures and treatment consisting of appliance therapy to treat malocclusion.

You must pay a Co-insurance of 50% of the fee for each orthodontic treatment, up to $750.

Each Participant is entitled to orthodontic treatment under this Contract subject to any applicable Deductible, Co-insurance or Co-payment as outlined herein.

We provide orthodontic benefits only when the orthodontist believes a satisfactory result can be achieved. Cross bite in permanent teeth is treated only when the orthodontist believes other conditions make orthodontic treatment necessary.

If a Participant needs multiple orthodontic treatments which are separated from each other by more than eighteen (18) months of retention therapy, the Participant will be required to pay new Co-insurance for the successive treatment, and any maximum benefit is restored.

You are responsible to pay the cost of repair or replacement of an orthodontic appliance. If You choose braces other than standard metal braces, We pay the applicable percentage of the cost of the metal braces. You pay the balance.

If orthodontic treatment is terminated for any reason before completion, Our obligation to provide benefits ceases with the date of termination. If services are resumed, benefits for the services, to the extent remaining, resume.

WHILE UNDER THE CARE AND TREATMENT OF DENTISTS OTHER THAN GROUP DENTISTS

You may receive Dental Services from a Dentist who is not a Group Dentist in the following cases:

1. Referral by Dental Group

If Your Group Dentist decides You need covered Dental Service not available from the Dental Group, the Dental Group will give You a written referral. You are then entitled to covered Dental Services as specified by the written referral rendered by the Dentist to whom You were referred.

2. Emergency Services

Emergency Services performed outside the Service Area are covered up to $50. You should receive follow-up care at Your assigned Dental Group. To obtain payment for Emergency Services, submit an itemized bill to Your Dental Group.

6 GENERAL EXCLUSIONS

Benefits do not include:

1. Dental Services not specifically described in this Contract.
2. Dental Services which are not Medically

Necessary.

3. Dental Services which are Experimental/Investigational.
4. Services or supplies which are otherwise Dental Services, when such services or supplies are furnished in connection with or as a result of a non-covered dental service.
5. Dental Services and Emergency Services with respect to congenital malformations or those primarily for cosmetic, or beautifying purposes. (This exclusion applies to existing teeth and not to congenitally missing teeth.).
6. Any Laboratory Charges, except when specifically provided in the contract.
7. Charges for any duplicate prosthetic device or other appliance; replacement of lost or stolen devices or appliances; the replacement of an orthodontic appliance.
8. Placement of bone grafts or extra-oral substances; treatment of cleft palate or anodontia; orthognathic surgery, including osteotomy procedures and LeForte I, II, and III procedures.
9. Bacteriologic studies, caries susceptibility tests, histopathologic examinations, and other oral pathologic procedures.
10. Gold foil restorations, or implants.
11. The cost of high noble metals, unless Medically Necessary to restore the tooth.
12. Any splinting procedure.
13. General anesthesia; injections of antibiotic drugs, IV sedation except when specifically provided in the Contract.
14. Free care or care for which a Participant would have no legal obligation to pay without this or any similar coverage.
15. Dental Service or Emergency Service
    a. that would be furnished to the Participant without charge;
    b. which the Participant would be entitled to have furnished or paid for, fully or partially, under any law, regulations or agency of any government; if this Contract were not in effect.
16. Dental Services or Emergency Services to the extent Medicare is the Participant's primary payor. Medicare is primary except where it is secondary payor by law. Where Medicare is primary, if the Participant does not apply for Medicare or comply with Medicare requirements, We will reduce Our benefits by the amount Medicare would have paid if the Participant had enrolled or complied.
17. Dental Service for temporomandibular joint (TMD) dysfunction or vertical dimension; appliances, restorations, or procedures to adjust vertical dimension or restore occlusion.
18. Dental Services and Emergency Services for or resulting from, injuries, diseases or conditions which occur in the course of employment and for which a Participant is eligible for compensation under any Workers' Compensation Act or Employer Liability Law. This applies whether or not the Participant recovers losses from a third party.
19. Dental Services resulting from diseases contracted or injuries sustained as a result of war, enemy action, or action of or serving in the Armed Forces of the United States or its allies or while serving in the Armed Forces of any country.
20. Dental Services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, academic institution or similar person or group.
21. Dental Services furnished prior to the Participant's Effective Date.
22. Dental Services and Emergency Services rendered or furnished after the date a Participant ceases to be covered. This does not include:

a. procedures (other than prosthetic services) commenced before, and completed in 1 visit within thirty-one (31) days following termination of coverage; or
b. prosthetic devices ordered and fitted before, and completed within sixty (60) days following termination of coverage.

23. Charges for telephone consultation, or the completion of insurance or a return to work/school forms and charges for failure to keep a scheduled visit with the Dentist; charges which have not been documented in provider records.
24. Hospital or physician services of any kind.
25. Additional orthodontic fees that are a direct result of lack of patient cooperation, including without limitation missed appointments and failure to wear appliances.
26. Federal, state, and local taxes on goods or services.
27. Dental Services or Emergency Services rendered by a member of the Participant's immediate family. Immediate family means the Participant's spouse, children, parents, grandparents, brothers and sisters and their spouses.
28. Reimbursement to the Participant or any dental office for the cost of Dental Services obtained from Dentists who are not Dental Group Dentists, unless the Dental Group authorizes in writing the Dental Services.
29. Any portion of a provider's charge which is more than the Maximum Allowed Amount We approve for payment.

LIMITATIONS

1. Your DENTACARE Center may restrict access to care if You fail to pay the required Co-insurance, Co-payment, or Deductible for Dental Services, Laboratory Charges, and charges for non-covered services. This limitation does not apply if a dental emergency exists. This restriction on access to care may be considered an unsatisfactory dentist-patient relationship which could lead to disenrollment.
2. This Contract does not cover any service, or a related service, which is a benefit under a hospital and/or surgical-medical group benefit plan offered by the same Group that covers the Participant.

7 HOW MAXIMUM ALLOWED AMOUNT IS DETERMINED

General

This section describes how We determine the amount of reimbursement for Dental Services. Reimbursement for dental services rendered by Network and Non-Network Dentists is based on this Booklet's Maximum Allowed Amount for the type of service performed.

The Maximum Allowed Amount for this Booklet is the maximum amount of reimbursement We will pay for services and supplies:

- that meet Our definition of Dental Services, to the extent such services and supplies are covered under your plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your Booklet.

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 Copayment or Coinsurance. In addition, when you receive Dental Services from a Non-Network Dentist, you may be responsible for paying any

difference between the Maximum Allowed Amount and the Dentist's actual charges. This amount can be significant.

When you receive Dental Services from a Dentist, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Dental 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. Our application of these rules does not mean that the Dental Services you received were not Medically Necessary. It means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. 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, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Dentist or other dental providers, We may reduce the Maximum Allowed Amounts 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 have already been considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Dentist is a Network Dentist or a Non-Network Dentist.

Network Dentist

A Network Dentist or participating Dentist is a Dentist who is in the contracted network for this specific Booklet or who has a participation contract with Us. For Dental Services performed by a Network Dentist or participating providers, the Maximum Allowed Amount for this Booklet is the rate the Dentist has agreed with Us to accept as reimbursement for the Dental Services. Because Network Dentists and participating providers have agreed to accept the Maximum Allowed Amount as payment in full for those Dental Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible, or have a copay or coinsurance. Please call Customer Service for help in finding a Network Dentist or participating provider or visit www.anthem.com.

Non-Network Dentist

Dentists who have not signed any contract with Us and are not in any of Our networks are Non-Network Dentists. **Certain benefits are not available when received from Non-Network Dentists. Please see the rest of this Booklet for details.**

For Dental Services You receive from a Non-Network Dentist, the Maximum Allowed Amount for this Booklet will be one of the following as determined by Us:

1. An amount based on Our managed care fee schedules used with Network Dentists, which We reserve the right to modify from time to time; or

2. An amount based on information provided by a third party vendor which may reflect comparable Dentists' fees and costs to deliver care; or

3. An amount negotiated by Us or a third party vendor which has been agreed to by the Network Dentist; or

4. An amount equal to the total charges billed by the Dentist, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

Dentists who are not contracted for this product but contracted for other products with Us are also considered Non-Network. For this Booklet, the Maximum Allowed Amount for services from these Dentists will be one of the four methods shown above unless the contract between Us and that Dentist specifies a different amount.

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

Customer Service is also available to assist you in determining this Booklet's Maximum Allowed Amount for a particular service from a Non-Network Dentist. In order for Us to assist you, you will need to obtain from your Dentist the specific procedure code(s) 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 final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Dentist.

Member Cost Share

For certain Dental Services and depending on your plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

We will not provide any reimbursement for non-covered services. You may be responsible for the total amount billed by your Dentist for non-covered services, regardless of whether such services are performed by a Network or Non-Network Dentist. Both services specifically excluded by the terms of your Booklet and those received after benefits have been exhausted are non-covered services. Benefits may be exhausted by exceeding, for example, your annual or lifetime maximum, benefit maximums or day/visit limits.

8 COORDINATION OF THE CONTRACT'S BENEFITS WITH OTHER BENEFITS

APPLICABILITY

This Coordination of Benefits ("COB") provision applies to This Plan when a Member has dental care coverage under more than one Plan, except to the extent this provision is superseded by the Medicare secondary payor rules. "Plan" and "This Plan" are defined below.

If this COB provision applies, the order of benefit determination rules are looked at first. The rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

1. Are not reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but
2. May be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. This reduction is described in Effect On The Benefits Of This Plan section below.

DEFINITIONS

When used in this Section only, these terms have the following meanings.

ALLOWABLE EXPENSE means a necessary, reasonable, and customary item of expense for

dental care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered is considered both an Allowable Expense and a benefit paid.

CLAIM DETERMINATION PERIOD means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan or any part of a year before the date this COB provision or a similar provision takes effect.

PLAN means any of the following which provides benefits or services for, or because of, dental care or treatment:

1. Group dental insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice dental coverage. It also includes dental coverage other than school accident-type coverage.
2. Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.
3. "No-fault" and group or group-type "fault" automobile insurance policies or contracts.

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

PRIMARY PLAN/SECONDARY PLAN The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering You.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

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

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan or Plans.

THIS PLAN means the part of the Contract that provides benefits for dental care expenses.

ORDER OF BENEFIT DETERMINATION RULES

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

1. The other Plan has rules coordinating its benefits with those of This Plan; and
2. Both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other Plan.

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

1. NON-DEPENDENT/DEPENDENT. The benefits of the Plan which covers You as an Employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent.
2. DEPENDENT CHILD/PARENTS NOT SEPARATED OR DIVORCED. Except as stated in rule 3, when This Plan and another Plan cover the same child as a Dependent of different persons (called "parents"):
    a. The benefits of the Plan of the parent whose birthday falls earlier in the calendar year are determined before those of the Plan of the parent whose birthday falls later in that calendar year; but

b. If both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in a. but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall determine the order of benefits.

3. DEPENDENT CHILD/SEPARATED OR DIVORCED PARENTS. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

   a. First, the Plan of the parent with custody of the child;
   b. Then, the Plan of the spouse of the parent with custody of the child; and
   c. Finally, the Plan of the parent not having custody of the child.

   Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the dependent child shall be determined according to rule 2.

   However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. ACTIVE/INACTIVE EMPLOYEE. The benefits of a Plan which covers You as an Employee who is neither laid off nor retired or as Your Dependent are determined before those of a Plan which covers You as a former employee or as Your Dependent. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

5. CONTINUATION COVERAGE. The benefits of a Plan which covers You as an Employee, member, or subscriber, or as a Dependent of such a person, are determined before those of a Plan which covers You as a person on state or federal continuation. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

6. LONGER/SHORTER LENGTH OF COVERAGE. If none of the above rules determines the order of benefits, the benefits of the Plan which covered You as a member or subscriber longer are determined before those of the Plan which covered You for the shorter time.

EFFECT ON THE BENEFITS OF THIS PLAN

This Section applies when, in accordance with the Order of Benefit Determination Rules, This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to below as "the other Plans".

The benefits of This Plan will be reduced when the Allowable Expenses in a Claim Determination Period are less than the sum of:

1. The benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

2. The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made.

In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. We have the right to decide which facts We need. We may get needed facts from, or give them to, any necessary organization or person. 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 We need to pay the claim.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, We may pay that amount to the organization which 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" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments We made is more than We should have paid under this COB provision, We may recover the excess from one or more of:

1. The persons We have paid or for whom We have paid;
2. Insurance companies; or
3. Other organizations.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

9 DISENROLLMENT

Your coverage depends on Your continued eligibility and timely payment of premium. But, We can disenroll any Participant and his/her family members who are Participants if:

1. You or the Group fail to pay premium on time;
2. the Participant submits fraudulent information;
3. the Participant allows a non-Participant to use the identification card to obtain Dental Services;
4. the Participant commits acts of physical or verbal abuse which pose a threat to Group Dentists or other DENTACARE Participants;
5. the Participant, other than a child Dependent Participant, moves outside the Service Area;
6. the Participant (except for a Dependent attending school or a child Dependent Participant) lives outside the Service Area more than three (3) months a year;
7. the Participant fails to establish a satisfactory Dentist-patient relationship with a Group Dentist. We cannot disenroll the Participant for this reason unless We give him/her;

a. help in establishing the relationship;
b. a chance to choose a new Group Dentist; and
c. a chance to file a grievance.

We cannot disenroll a Participant for:

1. his/her health;
2. his/her failure to follow a prescribed course of treatment; or
3. his/her administrative actions. This includes failure to keep an appointment.

We will give You ten (10) days notice of disenrollment.

Subsequent to disenrollment for any reason other than nonpayment of the amount due. We shall make arrangements to provide alternate coverage to You. Such coverage shall terminate when you become eligible for coverage in your own right or have the opportunity to change coverage, whichever comes first.

10 TERMINATION AND CONTINUATION

TERMINATION OF INDIVIDUAL COVERAGE

Except as specified in the Contract, a Participant's coverage ends on the earliest of the following dates:

1. The date the Contract between the Group and Us terminates. It is the Group's responsibility to notify all Participants of the termination of coverage.
2. The last day of the month in which the Participant no longer meets the eligibility requirements.
3. The last day of the month in which the last payment contribution is made by or on behalf of the Participant.

The Group must notify Us of the termination of a Participant's coverage on or before the termination date. Except as stated otherwise within this Contract, no Benefits are available to a Participant for Covered Services rendered after the date coverage ends.

In the event that any care is required by a Participant after his rights to Benefits have terminated, the expenses incurred for such care shall be the sole responsibility of the Participant or the person legally responsible for his care.

The provision entitled Continuation of Coverage Under COBRA contains the continuation requirements of the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. The intent of this provision is to comply with the minimal legislative requirements of COBRA. It is the group's responsibility to determine if COBRA applies.

CONTINUATION OF COVERAGE UNDER COBRA

1. The following persons who have been covered under this Contract may elect to continue coverage under this Contract. The following persons will be eligible for continuation coverage if the occurrence of one of the events results in the loss of coverage under this Contract:
    a. The spouse of an Employee, upon the occurrence of one of the following events:
        1. Death of the Employee;
        2. Termination of the Employee's eligibility of coverage under this Contract other than termination of eligibility for coverage due to discharge for gross misconduct shown in connection with his/her employment (termination includes a loss of eligibility due to a reduction in hours);

3. Eligibility of the Employee for Medicare;
4. Divorce or legal separation of the Employee.

b. The Dependent child of an Employee, upon the occurrence of the following events:

1. Death of the Employee;
2. Termination of the Employee's eligibility of coverage under this Contract other than termination of eligibility for coverage due to discharge for gross misconduct shown in connection with his/her employment (termination includes a loss of eligibility due to a reduction in hours);
3. Eligibility of the Employee for Medicare;
4. Cessation of the eligibility of a child of the Employee as a Dependent under this Contract.

c. The Employee, upon the occurrence of the following event:

1. Termination of the Employee's eligibility of coverage under this Contract other than termination of eligibility for coverage due to discharge for gross misconduct shown in connection with his/her employment (termination includes a loss of eligibility due to a reduction in hours).

d. The Retired Employee, his spouse and Dependents, upon the occurrence of the following event;

1. The Group's filing of a Chapter 11 bankruptcy petition.

e. The Spouse of a deceased Retired Employee upon the occurrence of the following event:

1. The Group's filing of a Chapter 11 bankruptcy petition.

2. The Employee or the Participant whose coverage is terminated due to Divorce, legal separation or cessation of eligibility for Dependent coverage shall provide the Group notice of such event within sixty (60) days of its occurrence.

3. If the Group is notified to terminate coverage due to the occurrence of any of the events described in subparagraph one (1), the Group shall provide the terminated Participant written notification of the right to continue coverage under this Contract and the payment amounts required for continued coverage including the manner, place and time in which the payment shall be made. This notice shall be given not more than fourteen (14) days after the Group receives notice to terminate coverage.

4. Except as provided for in subparagraph seven (7) (e)(3), the payment amount for continued coverage under this Contract may not exceed one hundred two percent (102%) of the rate in effect for a Group Employee, including the Group contribution, if any, for this Contract. The notice may be sent to the terminated Participant's home address as shown on the records of the Group.

5. A terminated Participant, or with respect to a minor, the parent or guardian of the terminated Participant must elect to continue coverage under this Contract and tender to the Group the Premiums required within the election period. This election period shall extend for a period of sixty (60) days from the later of the date of the event as set forth in subparagraph one (1) that led to termination or the date the terminated Participant receives notification of the right to continue coverage, pursuant to subparagraph three (3). Furthermore, notwithstanding any other provisions of the Contract, such terminated Participant shall have a period of forty-five (45) days following the date of election of continued coverage under this Contract to tender to the Group the required premiums for such coverage. The Participant must tender to the Group during this forty-five (45) day period the Premiums required for the continued coverage provided from the date coverage

would have terminated to the date of the election of continued coverage under this Contract. A terminated employee Participant may also elect coverage for Dependent children born to or placed for adoption with the employee during a period of continuation coverage.

6. A terminated Participant who continues coverage under this Contract shall be treated in the same manner as a similar situated Participant whose coverage under the Contract has not terminated.

7. Pursuant to subparagraph five (5) above, coverage of the terminated Participant electing to continue coverage shall continue without interruption until the coverage is terminated as indicated below. If the terminated Participant is an Employee who is eligible for continued coverage, coverage of the covered Dependents of the Employee shall also continue without interruption until coverage is terminated. Continued coverage may not terminate until the earliest of the following:

   a. the date on which the Group ceases to provide this Contract to any Employees;

   b. the date on which the terminated Participant fails to pay a required premium by the end of the grace period allowed to the Group under this Contract;

   c. the date on which the terminated Participant becomes entitled to Medicare benefits, unless the terminated Participant is a Retired Employee, the dependent of a Retired Employee or the spouse of a deceased Retired Employee and is eligible for continuing coverage pursuant to paragraphs 1(d) and 1(e);

   d. the date on which the terminated Participant becomes covered as an Employee or otherwise under any other Group benefit contract, unless this Contract limits or excludes coverage for any Pre-Existing Condition of the Participant;

   e. the date that is eighteen (18) months after termination of the Employee's coverage under this Contract other than termination of eligibility for coverage due to discharge for gross misconduct shown in connection with his employment. However,

      1. Should the Employee be determined by the Social Security Administration to be disabled at any time within the first 60 days of continuation coverage, coverage of the terminated Employee and of his covered Dependents shall extend beyond the eighteenth (18th) month until the earlier of the date that the Employee is no longer disabled or the date that is twenty-nine (29) months after the termination of eligibility for coverage under this Contract; or
      2. Should the terminated Employee not be disabled, but a spouse or covered Dependent of the terminated Employee is determined to be disabled by the Social Security Administration at any time during the first 60 days of continuation coverage, the coverage of the disabled spouse or Dependents will extend for twenty-nine (29) months from the date of termination of eligibility of coverage.
      3. In order to be eligible for said extension, the terminated disabled Employee or the disabled Dependent must notify the Group of the Social Security Administration's determination within sixty (60) days of the determination, and before the end of the eighteenth (18th) month of continuation. The payment amount for continued coverage during the nineteenth (19th) through twenty-ninth (29th) month may not exceed one hundred fifty percent (150%) of the rate in effect for a Participant, including the

Group contribution, if any, for this Contract.

f. For Dependents other than the Dependents of a terminated Employee, or the spouse of a deceased Retired Employee, the date that is thirty-six (36) months after the occurrence of one of the following events. The event set forth in (e)(5), however, shall only be applicable to covered Dependents of a deceased Retired Employee;
   1. Death of the Employee;
   2. Eligibility of the Employee for Medicare;
   3. Divorce or legal separation of the Employee.
   4. Cessation of the eligibility of a child of the Employee as a Dependent under this Contract.
   5. Death of the Retired Employee subsequent to the Group's filing of a Chapter 11 bankruptcy petition.

g. the date of death for;
   1. A Retired Employee if:
      a. the Group files a Chapter 11 bankruptcy petition and
      b. the Retired Employee retired on or before the bankruptcy filing.
   2. the spouse of a deceased Retired Employee if:
      a. the surviving spouse was covered under the Group Health Plan subsequent to the Retired Employee's death and
      b. the Retired Employee died prior to the Chapter 11 bankruptcy proceeding.

8. Participants, other than those eligible for coverage for life due to a bankruptcy filing, who experience more than one event as described in subparagraph one (1) will be eligible for continuation coverage for a period not to exceed thirty-six (36) months from the occurrence of the first such event. However, if an Employee's eligibility for Medicare precedes a termination of the Employee's eligibility for coverage, the Dependents of the Employee will be eligible to elect continuation coverage for the greater of (1) thirty-six (36) months from the date of Medicare entitlement or (2) eighteen (18) months from the date of termination.

9. The Premium for continued coverage under this Contract shall be paid to the Group. The Group shall collect, and We shall bill the Group for those Premiums. We shall charge the claims experience of individuals covered under this Contract pursuant to subparagraph one (1) against the claims experience of the Group.

10. Special COBRA rights apply to Employees who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days (or less) and only during the six months immediately after their group health plan coverage ended.

If You, the Employee, qualify for assistance under the Trade Act of 1974, You should contact the Group for additional information. You must contact the Group promptly after qualifying for assistance under the Trade Act of 1974 or You will lose these special COBRA rights.

11 GENERAL PROVISIONS

A. ENROLLMENT

Each newly hired employee shall be given the opportunity to apply for Benefits hereunder during the qualifying period established by the Group.

Notify the Group within thirty-one (31) days of any change of address or status. This includes changes due to birth, marriage, etc.

B. PARTICIPANT/PROVIDER RELATIONSHIP

Nothing herein contained shall interfere with the professional relationship between you and your Dentist.

The Plan shall in no way be responsible for any act or omission of any Dentist or other professional practitioner or their agents, or to provide Dental Service. The obligation of the Plan shall be limited solely to provide Benefits according to the provisions in the Contract.

The provisions of paragraph (1) notwithstanding, We reserve the right to accept or reject your selection of a Group Dentist or any other selected provider. We may require that you choose another Dental Group. If you choose to waive this choice, We may transfer the responsibility of your care to another Dental Group if it is in your or our best interests.

You may change Your choice of Dental Groups only during an Open Enrollment Period or if you move a significant distance from the original Dental Group's facility so that the facility's location is inconvenient to you.

C. RELEASE OF INFORMATION

1. You will do all things reasonably necessary to assist Us in determining benefits payable. This includes signing authorizations allowing Dentists or other persons or entities to release medical or dental records to Us.
2. You must send Us proof of Emergency Services You receive. This includes itemized bills, dental reports, records, X-rays, etc.

D. TRANSFER OF BENEFITS

No person, other than You or your covered Dependents are entitled to benefits under this coverage. You and Your covered Dependents give up the right to benefits if You or they transfer that right or aid anyone in obtaining benefits under this coverage. You and Your covered Dependents are liable for reimbursement to Us of any related monies We have paid.

E. SUBROGATION

You agree that We are subrogated to all rights to damages, reimbursement, or payment which arise out of an illness or injury, to the extent that We have paid, or are obligated to pay, benefits for the illness or injury. You agree that those rights are assigned to Us.

You also agree to cooperate with Us in Our recovery efforts, and not to compromise or hinder Our claim. We have the right to recover from anyone. However, We may not recover from You unless You have been made whole. Whether You have been made whole takes into account Your degree of fault. A judge will decide any disputes as to whether You have been made whole.

F. REIMBURSEMENT

You will reimburse Us for benefits provided or paid for which a Participant was not eligible. The reimbursement is due and payable immediately upon notification and demand. We can recover benefits paid from any person or provider to whom the payments were made. At Our option, later payment or allowance for benefits may be reduced or refused as a set-off toward reimbursement.

G. DETERMINATION OF MAXIMUM ALLOWED AMOUNT

1. When it is necessary for any purpose in the administration of this Contract or for the determination of the rights of any party or Participant to determine a monetary value of Benefits provided to a Participant under this Contract or any other Plan Contract, such monetary value shall be the charges that would have been made by the person providing the service if this Contract were not in effect.
2. If a Participant is eligible for Dental Services under more than one Plan Contract, such Participant shall be entitled to an allowance therefore equal to the Maximum Allowed Amount for the aggregate Dental Services available under such Plan Contracts, up to but not exceeding the total incurred regular Maximum Allowed Amount for all such Dental Services.

H. INTERRUPTION OF BENEFIT RENDITION

In the event that, due to circumstances not reasonably within the control of the Plan or the Dental Group, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, acts of the public authorities, or similar causes, the rendition of Benefits hereunder is delayed or becomes impractical, the Plan shall not have any liability or obligation on account of such delay or failure to provide Benefits.

I. NOTICE OF CLAIM

1. Your identification card must be presented to the Dentist, or the fact of participation made known, when a Participant applies for benefits.
2. You or a Dentist must submit a claim containing written proof of loss to Us within ninety (90) days of the date of service. The date of service is the day the service or supply is provided. This claim must include proof of services or supplies rendered and expenses incurred. It must include the information necessary for Us to determine what benefits are payable.
3. If a claim is not submitted within ninety (90) days of the date of service, it still will be accepted and processed if:
   a. it is submitted as soon as reasonably possible within fifteen (15) months of the date of service; and
   b. We are not hurt by the delay.
4. No benefits are provided for a claim submitted more than fifteen (15) months after the date of service.

J. GRIEVANCE PROCESS

You have the right to file a Grievance with Us whenever You are not satisfied with the services or benefits You receive. This Grievance must be filed in writing to Us. Your Grievance should include the following:

1. Your Participant identification number.
2. If claim related, date of service, provider's name, amount of claim, patient's name and reason you believe the claim should be paid.
3. If not claim related, description of problem and resolution you are looking for.

It will be helpful if You identify Your letter as a Grievance. We will acknowledge Your Grievance within five (5) days of receiving it. We will examine all relevant facts including any material or records which you submit. The Participant has the right to inspect all documents and records pertaining to his/her claim for benefits. You may appear before the Grievance Committee to present more information You wish the Committee to consider. We will notify You of the meeting time and place of the Committee meeting at least seven (7) days in advance. The Grievance Committee will report its final decision to You within thirty (30) days of receiving Your Grievance. If special circumstances require a longer review period, We will notify You of the reason

why, and when a decision may be expected. If We need the extra days, We will provide Our written decision within 60 days of receiving the Grievance.

In certain circumstances, you may request that We review your Grievance within seventy-two (72) hours. You may do this if the standard Grievance resolution process would include any of the following:

1. Serious jeopardy to your life or health or your ability to regain maximum function;
2. A situation where, in the opinion of a Dentist with knowledge of your medical condition, You would be subjected to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Grievance; or
3. A situation where, in the opinion of a Dentist with knowledge of your medical condition, that you must receive the treatment that is the subject of the Grievance right away.

You may file an expedited Grievance via a phone call to Us. You must provide the pertinent information listed above. We will resolve the expedited Grievance within seventy-two (72) hours of receiving it.

You can also contact the OFFICE OF THE COMMISSIONER OF INSURANCE, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the OFFICE OF THE COMMISSIONER OF INSURANCE by writing to:

OFFICE OF THE COMMISSIONER OF INSURANCE
Complaints Department
P. O. Box 7873
Madison, WI 53707-7873

or You can call 1-800-236-8517 outside of Madison or 266-0103 in Madison and request a complaint form.

K. LEGAL ACTION

No legal action may be started against Us until the earlier of:

1. Sixty (60) days after the Participant files notice of claim and completes the Grievance process; or
2. The date we deny the claim and the Participant completes the Grievance process.

No legal action may be started against Us later than three (3) years from the time written proof of loss was required to be filed. The Participant must file written proof of loss within fifteen (15) months of the date of service. This means any legal action must be started within fifty-one (51) months of the first date of services on which the action is based.

L. MISREPRESENTATIONS

No statement made by You with respect to a Participant's insurability, except fraudulent misstatements, will be used to void Your coverage or to deny a claim for benefits for services rendered or a disability starting after the coverage has been in effect for two (2) years.

M. APPLICABLE LAW

The Contract shall be construed under, enforced in accordance with and governed by the laws of the State of Wisconsin. If any provision of this Contract is found to be invalid, such provision shall be deemed modified to comply with applicable law and the remaining terms and provisions of this Contract, shall remain in full force and effect.

N. BENEFITS

1. If benefit levels change under this Contract, You are entitled to the level of benefits in effect on the date services or supplies were rendered.
2. You may request an advance determination as to whether a treatment, service, or supply is a covered Dental Service. Submit the request in writing to the Customer Service department of the regional

service center responsible for servicing the Group. Where We give prior written approval, We pay benefits if, at the time the treatment, service, or supply is provided:

a. The Participant's coverage is in force; and
b. Our approval has not expired.

3. Benefits under this plan will be paid only if the We decide in Our discretion that the applicant is entitled to them. The Group gives Us the discretionary authority to determine eligibility for coverage and benefits, and to construe the terms of the Contract. Furthermore, We have the right to determine the parameters used to identify claims that will be investigated. Our decisions shall not be overturned unless determined to be arbitrary and capricious.
4. We will consider alternative treatment plans proposed by You or on Your behalf. As part of this, We may extend benefits for services which are not Covered Services. The services must be Medically Necessary, cost-effective for Us, and feasible. We do this on a case-by-case basis. We may stop the extra benefits at any time.

O. ALTERNATIVE TREATMENT PLANS

We will consider alternative treatment plans proposed by or for a Participant. As part of this, We may extend benefits for services which are not covered services. The services must be Medically Necessary, cost-effective, and feasible. We do this on a case-by-case basis. We may stop the extra benefits at any time.

P. MAXIMUM ALLOWED AMOUNT

You may contact us at the Customer Service number listed in the front of the booklet prior to having a procedure performed to determine if the provider's estimated charge is the amount We will use to calculate Your Co-insurance liability (the Maximum Allowed Amount). You must provide Us with the following information:

1. Date of service,
2. Place of service,
3. Valid five (5) digit C.P.T. or A.D.A. code; and
4. Provider's estimated charge.

If you agree to pay a higher amount ("prior agreement") to a provider, you must pay the difference between Our allowance and your provider's charge. "Prior agreement" means you either knew of the fee or made an oral, written, or implied agreement to pay a specific fee. Sometimes, an agreement with a provider as to the appropriateness of the fee cannot be reached. In such a case, if you decide to pay the difference between your Plan's payment and the provider's charge, you are responsible for the payment of the balance. Although it does not occur often, if there has not been a prior agreement between you and the provider as to the fee, and if you haven't paid the remaining balance, We can help. If your unpaid balance is turned over to a collection agency, or if you get a summons (notice to appear in court), call or write Customer Service at once because We will not re-open the case for you once judgment once judgment has been entered. We will then contact the provider again and/or the collection agency and try to resolve the matter. We will assist you in notifying the appropriate credit bureau, when necessary, to help assure that your credit rating is protected. We will also defend you if the case goes to court. You must help Us in the defense of a lawsuit by promptly forwarding necessary legal papers and data to Us as well as by testifying, getting witnesses, and whatever else may be required to defend the lawsuit. We have the right to decide when to settle a lawsuit, or continue to defend it through ultimate appeal. If the court finds that a higher fee is to be paid, your Plan will pay it, subject to the terms of your Plan. You are then "held harmless," or not responsible, for payment of the fee. We will also pay for any legal or court costs that result from the court action, We will not pay for any costs due to your failure to follow provider's advice or neglect in paying your provider's bill for charges that are part of Our Maximum Allowed Amount.

Q. IMPORTANT NOTE

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Contract constitutes a contract solely between the Group and Compcare Health Services Insurance Corporation, dba Anthem Blue Cross and Blue Shield (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Wisconsin. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

MASTER DOMESTIC PARTNER BENEFITS RIDER TO PREFERRED GROUP PLAN

This Domestic Partner Benefits Rider amends the Definitions, Eligibility, Termination, and General Provisions sections of the above-referenced plan as issued under form number X-2363 (2006), to allow for dependent coverage of Domestic Partners and their children, as specified below. Benefits under this Rider are subject to all the terms and conditions of the policy, unless otherwise stated herein.

GENERAL DEFINITIONS

DOMESTIC PARTNERS are two individuals who, together, each meet all of the following criteria:

1. Are 18 years of age or older.
2. Are competent to enter into a contract.
3. Are not legally married to, nor the domestic partner of, any other person.
4. Are not related by marriage.
5. Are not related by blood closer than permitted under marriage laws of the State.
6. Have entered into the domestic partner relationship voluntarily, willingly and without reservation.
7. Have entered into a relationship which is the functional equivalent of a marriage, and which includes all of the following:
    a. living together as a couple;
    b. mutual support of each other;
    c. mutual commitment to one another;
    d. mutual responsibility for each other's welfare; and
    e. joint responsibility for the necessities of life.
8. Have been living together as a couple for at least six (6) months prior to registration with the Subscriber's employer.
9. Intend to continue the domestic partner relationship indefinitely, with the understanding that the relationship is terminable at the will of either partner.

ELIGIBILITY

Domestic Partners will be accepted for enrollment under the Plan only if they meet all of the applicable requirements below:

A. Criteria for Domestic Partners Eligibility

To be eligible to enroll as a Domestic Partner, the Subscriber and his/her Domestic Partner must satisfy all of the following:

1. Meet the definition of "Domestic Partners" as specified in the General Definitions section above;
2. The Subscriber and the Domestic Partner have declared that they:
    a. are in a committed, mutually exclusive relationship; and
    b. neither party has given the other party written notice rescinding that declaration.
3. Neither the Subscriber nor the Domestic Partner is:
    a. currently married or legally separated to or from any other person; and
    b. if either individual has been a party to an action or proceeding for divorce or annulment, then at least 6 months shall have elapsed since the date of the judgment termination that marriage.
4. Neither the Subscriber or Domestic Partner is currently engaged in a domestic partnership nor are they registered with a municipality, county, or state in a domestic partnership with a different partner. If either party has previously registered with a different partner, then at least 6 months shall have elapsed since the registration was terminated.
5. The Subscriber and his/her Domestic Partner currently reside at, and intend to continue to reside in, the same principal residence.
6. The Subscriber and his/her Domestic Partner must be jointly prepared to demonstrate at least or more of the following:
    a. evidence of the joint purchase and ownership of a home;
    b. a notarized or copy of a lease for a residence which identifies both the Subscriber and his/her Domestic Partner as responsible for payment of rent thereunder;
    c. evidence of a joint checking account which has been in effect and valid for at least 6 months;
    d. evidence of a joint savings account which has been if effect and valid for at least 6 months;
    e. a title and registration for a car showing joint ownership;
    f. evidence of joint use and liability for credit cards
    g. a certified copy of a policy declaration page specifying that the Domestic Partner is the beneficiary under a policy of life insurance issued to the Subscriber, or vice versa;
    h. evidence that the Domestic Partner is the beneficiary of the Subscriber's deferred compensation or other retirement plan;
        i. evidence of durable powers of attorney:
        ii. for property which satisfies ch. 243.07 and/or 243.10 Wis. Stats., or
    i. for health which satisfies ch. 155.05 and 155.10 Wis. Stats.;
    j. the Subscriber's last will and testatment which specifies that his/her Domestic Partner is the major recipient of the Subscriber's financial and real property assets; and/or
    k. other forms of documentary evidence which depicts significant joint financial interdependency between the Subscriber and his/her Domestic Partner;
7. The Subscriber and his/her Domestic Partner must be registered as a domestic partnership with the Subscriber's employer.

B. Criteria for Eligibility of Children of Domestic Partners

Children of the Subscriber's Domestic Partner will be subject to the same criteria that are listed

for Dependents in the Eligibility section of the benefit booklet.

C. Application & Effective Date

Coverage for Domestic Partners and their children will be subject to the same effective dates listed for Dependents in the Eligibility section of the benefit booklet. In addition, the following provision applies:

1. When an individual wishes to enroll as a Domestic Partner of the Subscriber, they may do so within 31 days of both:
    a. the establishment of a domestic partner relationship; and
    b. the execution of a fully completed "Affidavit of Domestic Partnership," certifying the date that the domestic partnership began and compliance with eligibility guidelines.

Enrollment is subject to all the terms and eligibility criteria covered in this rider, including the requirement that the couple has been together for at least six (6) months.

TERMINATION

Domestic Partners and their children will be subject to the same provisions listed for Dependents in the Termination section of the benefit booklet. In addition, the following provision applies:

A. Coverage for the Domestic Partner and their Child(ren)

When there is a change in one or more of the qualifying conditions as noted in the Criteria for Domestic Partners section above:

1. A Statement of Termination form must be filled out by the Subscriber within 31 days of the qualified change.
2. Coverage will terminate the last day of the month in which the change occurred.

B. Continuation and Conversion Coverage

The Domestic Partner, and any dependent children covered under this policy, will be subject to the same continuation and/or conversion provisions as specified in the benefit booklet.

GENERAL PROVISIONS

The Subscriber and Domestic Partner acknowledge that, in applying for this coverage, if false statements are made that cause Us to suffer any loss, we may bring civil action against either or both parties to recover Our losses, including attorney's fees.

Underwritten by Compcare Health Services Insurance Corporation

Notice of Privacy Practices

HIPAA Notice 2007

Anthem BlueCross BlueShield

Information That's Important to You

Every year, we're required to send you specific information about your rights, your benefits and more. This can use up a lot

of trees, so we've combined a couple of these required annual notices. Please take a few minutes to read about:

- State notice of privacy practices
- HIPAA notice of privacy practices
- Breast reconstruction surgery benefits

Want to save more trees? Go to anthem.com and sign up to receive these types of notices by e-mail.

State notice of privacy practices

As mentioned in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

Your personal information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter.

We may collect PI about you from other persons or entities, such as doctors, hospitals or other carriers.

We may share PI with persons or entities outside of our company — without your OK in some cases. If we take part in an activity that would require us to give you a chance to opt out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

HIPAA notice of privacy practices

This notice describes how health, vision and dental information about you may be used and disclosed, and how you can get access to this information with regard to your health benefits. Please review it carefully.

We keep the health and financial information of our current and former members private, as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For Payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For Health Care Operations: We use and share PHI for our health care operations. For

example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To You: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age; we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To Others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents). PHI can also be shared with organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for Workers' Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic Information: If we use or disclose PHI for underwriting purposes, we are prohibited from using or disclosing PHI that is genetic information of an individual for such purposes.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI, or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask him or her to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.
- Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. Customer Service representatives can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We are dedicated to protecting your PHI, and have set up a number of policies and practices to help make sure your PHI is kept secure. We keep your oral, written and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password Protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong out of areas where sensitive data is kept. Also, where required by law, our affiliates and nonaffiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

Please call Customer Service at the phone number printed on your ID card. Representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Breast reconstruction surgery benefits

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.

All applicable benefit provisions will apply, including existing deductibles, copayments and/or co-insurance. Contact your Plan administrator for more information.

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