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Capital Blue Cross Dental

BENEFITS BOOKLET

Issued by:
Capital Advantage Assurance Company®,
A Subsidiary of Capital Blue Cross
2500 Elmerton Avenue
Harrisburg, PA 17110

Please note:

To better serve you, members with questions about their coverage should call the Dedicated Member Services phone number provided for your group at **1-855-300-2273**. For your convenience, this number is also located on your identification card.

Capital

NONDISCRIMINATION AND FOREIGN LANGUAGE ASSISTANCE NOTICE

Capital Blue Cross and its family of companies comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Capital Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Capital Blue Cross provides free aids and services to people with disabilities or whose primary language is not English, such as:

- ✓ Qualified sign language interpreters.
- ✓ Written information in other formats (large print, audio, accessible electronic format, other formats).
- ✓ Qualified interpreters, and information written in other languages.

If you need these services, call 800.962.2242 (TTY: 711).

If you believe that Capital Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in person or by mail, fax, or email at:

Capital Blue Cross
PO Box 779880, Harrisburg, PA 17177-9880
800.417.7842 (TTY: 711), fax: 855.990.9001
CRC@capbluecross.com

If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW., Room 509F, HHH Building
Washington, D.C. 20201
Toll-free: 800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.

Language assistance

To talk to an interpreter in your language at no cost, call 800.962.2242 (TTY: 711).
Para hablar con un intérprete de forma gratuita, llame al 800.962.2242 (TTY: 711).
欲免费用本国语言洽询传译员，请拨电话 800.962.2242 (TTY: 711).
Để nói chuyện với thông dịch viên bằng ngôn ngữ của quý vị không phải mất phí, xin gọi 800.962.2242 (TTY: 711).
Для бесплатного разговора с переводчиком на своем языке, позвоните по тел.: 800.962.2242 (TTY: 711).
Fa koschdefrei schwetze mit me dolmetscher in deinre Schrooch, ruf 800.962.2242 uff (TTY: 711).
무료 전화 통역 서비스 800.962.2242 (TTY: 711).
Per parlare con un interprete nella vostra lingua gratis, chiami 800.962.2242 (TTY: 711).
للتحدث مجانًا إلى مترجم للغتك، يرجى الاتصال بـ 800.962.2242 (الهاتف النصي: 711)
Pour parler à un interpréter dans votre langue sans charges, téléphoner à 800.962.2242 (TTY: 711).
Um in Ihrer Sprache gebührenfrei mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800.962.2242 an (TTY: 711).
દુભાષીયા જોડે વાત કરવા, 800.962.2242 (TTY: 711) પર ફોન કરો.
Aby porozmawiac z tlumaczem w jezyku polskim, prosze zadzwonic na numer darmowy telefonu 800.962.2242 (TTY: 711).
Pou pale avèk yon entèprèt nan lang ou grastis, rele nan 800.962.2242 (TTY: 711).
ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្ទាល់មាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ សូមហៅទៅកាន់ 800.962.2242 (TTY: 711).
Para falar com um intérprete em seu idioma de graça, ligue para 800.962.2242 (TTY: 711).

Capital Blue Cross is an Independent Licensee of the Blue Cross Blue Shield Association.

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WELCOME

Thank you for choosing dental *coverage* from the Capital Blue Cross family of companies. We are eager for this opportunity to help you and your family on your health and wellness journey.

This *Benefits Booklet* (also known as "Certificate of Coverage") is provided to you as part of the *group contract* entered into between the *contract holder* and us. It explains the *benefits* provided to you under your group health plan. It also defines terms important for your understanding, itemizes what your plan pays for and how, and explains how you can make the most of this *coverage*. We have also included our contact information so you can reach us when you have questions or concerns.

There are five sections in the *Benefits Booklet* that we would like to call out to help you to better understand your dental *coverage*. You should take extra time to review the following sections:

1. **How to Access Benefits**, serves as a guide to using and making the most of this *coverage*.
2. **Summary of Cost Sharing and Benefits**, provides a summary of your *benefits* and any *benefit* limitations under this *coverage*.
3. **Schedule of Limitations/ Schedule of Exclusions**, lists the services limited or not covered under your plan.
4. **Claims Reimbursement**, offers important information on how to file a claim for *benefits*.
5. **Appeal Procedures**, details the appeal process so you know how to file an appeal, if needed.

Let's Get Started

We want this *Benefits Booklet* to be easy to read and understand. Here are some of our language and format choices to help:

- When we say "you" or "your," we mean you, the *subscriber*. We may also say "you" or "your" to mean the *member*, which is anyone covered under your plan (**"***dependents*").
- When we say "we," "us," or "our," we mean Capital Advantage Assurance Company.
- When we use a defined term in a section, we will use *italics* to alert you to look the word up, if you want or need to under ***Definitions***.
- We will use **boldface font** to call out section titles, like ***How to Contact Us***, so you can go to that section to learn more.

Of course, any time you have questions or concerns about your *coverage*, we encourage you to call Member Services. You will find their number on the back of your *identification (ID) card*.

IMPORTANT NOTICES

There are a few important points that you need to know about your dental *coverage* before you continue reading the remainder of this *Benefits Booklet*:

- This plan may not cover all your dental expenses. You should read this *Benefits Booklet* carefully to determine which dental services are provided as *benefits* under your *coverage*.
- To receive certain *benefits* and pay the least for your dental care, use *in-network providers*.
- *Benefits* may be subject to *cost sharing amounts,* including *copayments*, *deductibles*, and *coinsurance*. Refer to the **Summary of Cost Sharing and Benefits** section of this *Benefits Booklet* for specifics.
- *Benefits* are subject to review in accordance with the standards of generally accepted dental practice and may be subject to utilization management.
- We base our *coverage* determinations on whether a dental service is appropriate and is a *benefit* under this *coverage*. We do not reward individuals or *providers* for denying *coverage*. And we do not provide them financial incentives to encourage you to use fewer covered services.
- We may contract with other companies to provide certain services, including administrative services, relating to this *coverage*.
- This *Benefits Booklet* replaces any other *Benefits Booklet*, Certificates of Coverage, or Certificates of Insurance we may have issued to you previously under your *coverage* with the Capital Blue Cross family of companies.
- The *group contract* is nonparticipating in any divisible surplus of premium.
- The *group contract* is available for inspection at the office of the *contract holder* during regular business hours.

HOW TO CONTACT US

We are committed to providing excellent service to you. We offer you a variety of ways to connect with us to answer your questions, confirm your *benefits* and *coverage*, and more.

Online

Be sure to sign up for a secure account at CapitalBlueCross.com. With it, you can find your *benefits*, claims, and cost share balances. You can locate *in-network providers*; change personal information or request *ID cards*.

Member Services

Member Services representatives can answer your questions, confirm your *benefits* and *coverage*, and help you find *in-network providers*. Member Services can also help answer your questions about how to access *providers* who accommodate your physical disabilities or other special needs. This may include providing interpreting services in your preferred language or translating documents upon request. Language assistance is also available to disabled individuals. Information in Braille, large print or other alternate formats are available upon request at no charge.

Call	800-613-2624 or TTY users, 711 during normal business hours
Email	Complete the Contact Us form at CapitalBlueCross.com.
Write	Dental Service Center P.O. Box 21522 Eagan, MN 55121
FAX	855-485-0115
Walk In	2500 Elmerton Avenue Harrisburg, PA 17177 M-F 8 a.m. to 4:30 p.m.
Visit a Capital Blue Cross Connect health and wellness center	Go to CapitalBlueConnect.com or call 855.505.BLUE (2583) to make an appointment or just stop in. M-F 9 a.m. to 6 p.m., Sat. 9 a.m. to 1 p.m. **Promenade Shops at Saucon Valley** 2845 Center Valley Parkway Suite 404/409 Center Valley, PA 18034 **Patrick O'Donnell Pavilion** WellSpan Health Campus 12 St. Paul Drive Chambersburg, PA 17201 **Hampden Marketplace** 4500 Marketplace Way Enola, PA 17025 **Capital Blue Cross** 1221 Hamilton Street Allentown, PA 18102 **Apple Hill Medical Center** 25 Monument Rd., Suite 220A York, PA 17402

DEFINITIONS

The terms below have the following meanings whenever italicized in your *Benefits Booklet* or the *group contract*:

Allowable Amount: The payment level that we reimburse for *benefits* provided to you under your *coverage*.

- For *in-network providers*, the allowable amount is the amount provided for in the contract between the *provider* and us, unless otherwise specified in this *Benefits Booklet*.
  - For *out-of-network providers*, the allowable amount is: allowable amount determined by *Capital* according to the BlueCross Dental PPO Preferred allowance.

Benefit Lifetime Maximum: The limit of *coverage* for a *benefit* payable by us under the *group contract* during the duration of a *member's coverage* under the *group contract*. Such limit is generally in the form of dollars. Benefit lifetime maximums are described in the **Summary of Cost Sharing and Benefits** section of this *Benefits Booklet*.

Benefit Period: The specified period of time during which charges for *benefits* must be incurred to be eligible for payment by us. A charge for *benefits* is incurred on the date you received the service or supply or upon completion of the procedure. The *benefit period* does not include any part of a calendar year during which you have no *coverage* under the *group contract*, or any part of a year before the date of this *Benefits Booklet* or a similar provision takes effect.

Benefit Period Program Maximum: The limit of *coverage* for a *benefit(s)* under the *group contract* within a *benefit period*. Such limits may be in the form of procedures or dollars. Benefit period program maximums are described in the **Summary of Cost Sharing and Benefits** section

Benefits: Those dental services and supplies covered under, and in accordance with, this *coverage*.

Benefits Booklet (Certificate of Coverage): This document, issued to *subscribers* as part of the *group contract* entered into by the *contract holder* and us. It explains the terms of this *coverage*, including the *benefits* available to *members* and information on how this *coverage* is administered.

Capital: Capital Advantage Assurance Company, issuer of this *coverage*, as indicated on the cover page of this *Benefits Booklet*.

Coinsurance: The percentage you pay of the *allowable amount* for a covered *service*. Coinsurance percentages, if any, are identified in the **Summary of Cost Sharing and Benefits** section or in the applicable rider to this *Benefits Booklet*.

Contract Holder: The organization or firm, usually an employer, union, or association, that contracts with us to provide or administer the *coverage* offered under your group health plan.

Copayment: A fixed amount you pay to the *provider* for covered service. Typically copayments are due at the time of service. Copayments, if any, are identified in the **Summary of Cost Sharing and Benefits** section or in the applicable rider to this *Benefits Booklet*.

Cosmetic Procedure: An elective procedure performed primarily to restore a person's appearance by surgically altering a physical characteristic that does not prohibit normal function, but is unpleasant or unsightly.

Cost Sharing Amount: The amount of covered services that you must pay. We subtract this amount from the *allowable amount* when we make payment to the *provider* for *benefits*. *Cost sharing amounts* include *copayments*, *deductibles*, and *coinsurance*.

Coverage: The program offered and/or administered by us which provides *benefits* for *members* covered under the *group contract*.

Deductible: The amount you pay for covered dental services before we start to pay. Deductibles are described in the **Summary of Cost Sharing and Benefits** section.

Dentist: *Dentists* include:

- Endodontist
- General Dentist
- Oral Surgeon
- Orthodontist
- Pediatric Dentist
- Periodontist
- Prosthodontist

Dependent: Any *member* of a *subscriber's* family or a *subscriber's* domestic partner who satisfies the applicable eligibility criteria, who enrolled under the *group contract* by submitting an *enrollment application* to us and for whom such *enrollment application* has been accepted by us.

Effective Date of Coverage: The date your *coverage* under the *group contract* begins as shown on our records.

Enrollment Application: The properly completed written or electronic application for membership submitted on a form provided by or approved by us, together with any amendments or modifications.

Fee Schedule: The predetermined fee maximums that we will pay for services performed by *out-of-network providers*, which are provided as *benefits* under this *coverage*. The fee schedule may be amended from time to time and may be adjusted based upon factors, including but not limited to, geographic location and *provider* types.

Group Application: The properly completed written and executed or electronic application for *coverage* the *contract holder* submits on a form provided by or approved by us, together with any amendments or modifications thereto.

Group Contract: The agreement between the *contract holder* and us pursuant to which we provide or administer *coverage* under this contract to eligible persons. The group contract is made up of four different documents: the *group policy/contract*, the *group application*, the *enrollment applications*, and this *Benefits Booklet*.

Group Effective Date: The date specified in the *group policy/contract* as the original date that the *group contract* became effective.

Group Enrollment Period: A period of time established by the *contract holder* and us from time to time, but no less frequently than once in any 12 consecutive months, during which eligible persons may enroll for *coverage*.

Group Policy/Contract: The legal agreement between the *contract holder* and us for administration and/or *coverage* of *benefits*.

Identification (ID) Card: The card issued to the *member* that evidences *coverage* under the terms of the *group contract.*

Immediate Family: The *subscriber's* or *member's* spouse, domestic partner, parent, step-parent, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, son-in-law, child, step-child, grandparent, or grandchild.

In-Network Provider: A *dentist* who is properly licensed, and has a contract with us to provide *benefits* under this *coverage*.

Investigational: For the purposes of the *group contract*, a drug, *treatment*, device, or procedure is investigational if any of the following apply:

- It cannot be lawfully marketed without the approval of the Food and Drug Administration ("FDA") and final approval has not been granted at the time of its use or proposed use for a period of up to six (6) months following FDA approval, unless otherwise provided in our applicable medical policies.
- It is the subject of a current investigational new drug or new device application on file with the FDA.
- The predominant opinion among experts as expressed in medical literature is that usage should be substantially confined to research settings.
- The predominant opinion among experts as expressed in medical literature is that further research is needed in order to define safety, toxicity, effectiveness or effectiveness compared with other approved alternatives.
- It is not investigational in itself, but would not be medically necessary except for its use with a drug, device, *treatment*, or procedure that is investigational.

In determining whether a drug, *treatment*, device or procedure is investigational, the following information may be considered:

- Your medical records.
- The protocol(s) pursuant to which the *treatment* or procedure is to be delivered.
- Any consent document you have signed or will be asked to sign, in order to undergo the *treatment* or procedure.
- The referred medical or scientific literature regarding the *treatment* or procedure at issue as applied to the injury or illness at issue.
- Regulations and other official actions and publications issued by the federal government;

- The opinion of a third party medical expert in the field, obtained by us, with respect to whether a *treatment* or procedure is investigational.

Level of Coverage: The level of payment made by us to an *in-network provider* or an *out-of-network provider* described in the **Summary of Cost Sharing and Benefits** section.

Member: A *subscriber*, *dependent* or "Qualified Beneficiary" (as defined under COBRA) enrolled for *coverage* and entitled to receive covered services under the *group contract* in accordance with its terms and conditions. For the appeal processes, the term includes parents of a minor *member* as well as designees or legal representatives who are entitled or authorized to act on behalf of the *member*. The term member is sometimes identified with the pronouns "you" and "your" in this *Benefits Booklet.*

Open Enrollment: A specific time period during each calendar year when the *contract holder* permits its employees or *members* to make enrollment changes.

Out-of-Network Provider: A *provider* who is not under contract with us or a *provider* who is not an *in-network provider* of the Dominion Dental Services Inc. network.[1]

Out of Pocket Maximum: A specified dollar amount of *deductible*, *copayment* and *coinsurance* expense incurred by you or your family, if applicable, for covered services in a *benefit period*. After you have paid this amount, you are no longer required to pay any portion of the *allowable amount* for *benefits* during the remainder of that *benefit period*. The amount of, and types of cost sharing applied to, the out of pocket maximum is described in the **Summary of Cost Sharing and Benefits** section.

Pre-Treatment Estimate: A pre-treatment estimate gives a nonbinding estimate of how much of a proposed *treatment* plan may be covered under your dental program and what your out-of-pocket cost may be.

Provider: A person or practitioner licensed (where required) and performing services within the scope of such licensure and as identified in this *Benefits Booklet*. *Providers* include *in-network providers* and *out-of-network providers*.

Retiree: A former employee of the *contract holder* who meets the *contract holder's* definition of a retired employee and to whom the *contract holder* offers *coverage* under the *group contract*, if any. The *contract holder* must designate and we must agree that one or more classes of retired former employees of the *contract holder* are eligible to receive *coverage* for *benefits* under the *group contract* in order for a person to qualify as a retiree.

Service Area: The following 21 Pennsylvania counties in which we offer *coverage*: Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Lehigh, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union, and York.

Services: *Treatment* performed by a *dentist* or under his/her supervision and direction and when necessary, customary and reasonable, as determined by us, using standards of generally accepted dental practice.

Subscriber: A person whose employment or other status, except for family dependency, is the basis for eligibility for enrollment for *coverage* under the *group contract*, who enrolled under the *group contract* by submitting an *enrollment application* to us and for whom such *enrollment application* has been accepted by us. Subscriber may include, without limitation, a *retiree*. A subscriber is also a *member*.

Treatment: A caring for or dealing with an oral condition.

Treating Dentist Statement: The written report of a series of procedures recommended for the *treatment* of a specific dental disease defect or injury, prepared for you by a *dentist* as a result of an examination made by such *dentist*.

[1]On behalf of Capital Blue Cross, Dominion Dental Services Inc., d/b/a/ Dominion National, assists in the administration of Capital Blue Cross Dental benefits. Dominion Dental is an independent company.

HOW TO ACCESS BENEFITS

ID Card

Your *ID card* is the key to accessing the *benefits* provided under this *coverage* with us.

You should show your *ID card* and any other ID cards for other dental coverage **each time you seek dental services**. *Providers* use the information from your *ID card* to submit *claims* for processing and payment.

Important Information About Your *ID card*:

- The words "Capital Blue Cross Dental" on the front of the card inform *providers* that you have dental *coverage* with us.
- On the back of the *ID card*, you will find the Capital Blue Cross Dental telephone number.

Please call Member Services if any information on your *ID card* is incorrect or if you have questions. Remember to destroy old *ID cards* and use only the most recent *ID card.*

Obtaining Benefits for Dental Services

We classify *providers* (*dentists*, *oral surgeon*, *orthodontist*, and so on) as either "in network" or "out of network." (You may have also heard the term "participating" or "nonparticipating." These terms mean the same thing.) The *provider* you select is — without limitation — in charge of your care, but your costs will generally be less if you choose an *in-network provider*.

Stay current about your *providers*. To confirm your *providers* are in network, go to CapitalBlueCross.com or call Member Services. You will find their number on the back of your *ID card*.

NOTE: Some *in-network providers* have agreed to extend deeper discounts or allowances; such providers are identified by *Capital* as "BlueCross Dental PPO Preferred" *providers*. When you choose a BlueCross Dental PPO Preferred *provider*, you may experience even greater savings over other *in-network providers*. Not all *in-network providers* offer as deep a discount as designated BlueCross PPO Preferred *providers*.

Services Provided By In-Network Providers

In-network providers agree to accept our payment for covered *benefits* - along with any applicable *cost sharing amounts* that you are obligated to pay under the terms of this *coverage* - as payment in full. You can maximize your *coverage* and minimize your out-of-pocket expenses by visiting an *in-network provider*.

All *in-network providers* must seek payment, other than *cost sharing amounts*, directly from us. ***In-network providers* may not seek payment from you for *services* that qualify as *benefits*.** However, an *in-network provider* may seek payment from you for noncovered services, including specifically excluded services (e.g., *cosmetic procedures*, *investigational* procedures, etc.), or *services* in excess of *benefit lifetime maximums* or *benefit period maximums*. The *in-network provider* must inform you before performing the noncovered services that you may be liable to pay for these services, and you must agree to accept this liability. Some *in-network providers* have agreed to bill you our *allowable amount* or the *provider's* charge, whichever is less, for noncovered services or services in excess of *benefit lifetime maximums* or *benefit period maximums.* You should check with your *provider* to determine applicability.

We will establish a hierarchy of *in-network providers* when the *provider* participates under multiple *Capital* dental networks.

The status of a *dentist* as an *in-network provider* may change from time to time. It is your responsibility to verify a *provider's* current network status. To find an *in-network provider*, you can go to CapitalBlueCross.com or call 1-800-613-2624.

Services Provided By Out-of-Network Providers

Services provided by *out-of-network providers* may require you to pay higher *cost sharing amounts* or may not be covered *benefits*. If services are covered, *benefits* will be reimbursed at the *allowable amount* applicable to this *coverage*. Information on whether *benefits* are provided when performed by an *out-of-network provider* and the applicable level of payment for such *benefits* is noted in the **Summary of Cost Sharing and Benefits** section.

Because *out-of-network providers* are not obligated to accept our payment as payment in full, you may be responsible for the difference between the *provider's* charge for that service and the amount we paid for that service. This difference between the *provider's* charge for a service and the *allowable amount* is called the balance billing charge. There can be a significant difference between what we pay for the service and what the *provider* charged. Unless you authorize payment directly to the *out-of-network provider*, all payments are made directly to the *subscriber*; and then you are responsible for reimbursing the *provider*. Additional information on balance billing charges can be found in the **Cost Sharing Descriptions** section.

Out-of-Country Services

When you travel outside the United States and need dental care you should go to the nearest appropriate treatment facility. When you receive out-of-country services, you must pay for *treatment* at the time of service and get a detailed receipt from the treating *provider*. In addition to providing the *provider's* name and address (including country), the receipt should describe the *services* performed by the *provider* and indicate the tooth or teeth that were treated. It should also indicate whether the *provider's* charges were billed in U.S. dollars or another currency.

Reimbursement is subject to the terms and conditions of your dental *coverage*, and is based on the out-of-network *benefit* provided through the *group contract*.

SUMMARY OF COST SHARING AND BENEFITS

The following table provides a summary of the applicable *cost sharing amounts* and *benefits* provided under this *coverage*.

The *benefits* listed in this section are covered when provided by a properly licensed *dentist* within the standards of generally accepted dental practice and in accordance with our utilization management requirements (when required).

It is important to remember that this *coverage* is subject to the exclusions, conditions, and limitations as described in this *Benefits Booklet*. Please see the **Cost Sharing and Benefit Descriptions**, **Schedule of Limitations,** and **Schedule of Exclusions** sections for a specific description of the *benefits* and *benefit* limitations provided under this *coverage*.

SUMMARY OF COST SHARING AND BENEFITS		
You will be responsible for paying the deductible, copayments and coinsurance percentage reflected in this chart. Unless otherwise stated, services that apply a copayment do not require that the deductible be satisfied first. Out-of-network providers may balance bill you, which would be additional costs to you over and above any deductible, copayments and coinsurance.		
	Amounts You Are Responsible For:	
	In-Network Providers	**Out-of-Network Providers**
Deductible (per benefit period)	$50 per member $150 per family	
Benefit Period Program Maximum is $2,000 per member	When you reach your program maximum, you pay 100% until the end of the benefit period.	

SUMMARY OF BENEFITS		
	Amounts You Are Responsible For:	
	In-Network Providers	***Out-of-Network Providers**
DIAGNOSTIC AND PREVENTIVE SERVICES		
Routine Exams**	No charge, Deductible waived	No charge, Deductible waived
X-rays • Periapical X-rays • Bitewing X-rays • Full Mouth or Panoramic X-rays	No charge, Deductible waived	No charge, Deductible waived
Fluoride Treatments: for dependent children to age 19	No charge, Deductible waived	No charge, Deductible waived
Prophylaxis	No charge, Deductible waived	No charge, Deductible waived
Sealants: for dependent children to age 14	No charge, Deductible waived	No charge, Deductible waived
Space Maintainers: for dependent children to age 14	No charge, Deductible waived	No charge, Deductible waived
Palliative Emergency Treatment (acute condition requiring immediate care)	No charge, Deductible waived	No charge, Deductible waived
Consultations	No charge, Deductible waived	No charge, Deductible waived
BASIC SERVICES		
Basic Restorative (amalgam “silver” fillings and composite “white” fillings)	20% coinsurance after Deductible	20% coinsurance* after Deductible
Endodontics (procedures for pulpal therapy and root canal filling)	50% coinsurance after Deductible	50% coinsurance* after Deductible
Periodontics (treatment to the gums and supporting structures of the teeth; surgical and nonsurgical periodontal treatment is covered)	50% coinsurance after Deductible	50% coinsurance* after Deductible
Oral Surgery (extraction and oral surgery procedures, including pre- and post-operative care; general anesthesia is covered when used in conjunction with covered oral surgical procedures.)	50% coinsurance after Deductible	50% coinsurance* after Deductible

SUMMARY OF BENEFITS		
	Amounts You Are Responsible For:	
	In-Network Providers	***Out-of-Network Providers**
MAJOR SERVICES		
Major Restorative (crowns, inlays, onlays)	50% coinsurance after Deductible	50% coinsurance* after Deductible
Prosthodontics • Procedures for replacement of missing teeth by construction or repair of bridges and partial or complete dentures • Implant surgical placement and removal; implant supported prosthetics, including repair and recementation	50% coinsurance after Deductible	50% coinsurance* after Deductible
ORTHODONTICS		
Orthodontic Treatment (covered for dependent children to age 19; procedure for straightening teeth)	50% coinsurance, Deductible waived	50% coinsurance,* Deductible waived
Orthodontics Lifetime maximum is $500 per dependent child		

*Out-of-network providers may balance bill the member as described in the **Cost Sharing Description** section of this Benefits Booklet.
**We will pay for one additional exam and prophylaxis for pregnant Members

COST SHARING DESCRIPTIONS

This section describes the cost sharing that may be required under your *coverage*.

Because *cost sharing amounts* vary depending on your specific *coverage*, it is important that you refer to the **Summary of Cost Sharing and Benefits** section. That section shows the services that are covered and the applicable *cost sharing amounts* (*copayments*, *deductibles*, **and** *coinsurance*) for each *benefit*.

Application of Cost Sharing

All payments made by us for *benefits* are based on the *allowable amount*. The *allowable amount* is the maximum amount that we will pay for *benefits* under this *coverage*. Before we make payment, any applicable *cost sharing amount* is subtracted from the *allowable amount*.

Payment for *benefits* may be subject to any of the following *cost sharing amounts*:

- *Deductibles*
- *Copayments*
- *Coinsurance*

In addition, you are responsible for paying any of the following:

- Balance billing charges, which you pay due to an *out-of-network provider* that exceed the *allowable amount*.
- Services for *benefits* not provided under your *coverage* regardless of the *provider's* network status.

Deductible

A *deductible* is a dollar amount that an individual *member* or a *subscriber's* entire family must incur before *benefits* are paid under this *coverage*. The *allowable amount* that we otherwise would have paid for *benefits* is the amount applied to the *deductible*. Depending on your *coverage*, there may be a *deductible* amount applicable only to *benefits* received for *services* provided by *in-network providers* and a separate *deductible* amount applicable only to *benefits* received for *services* provided by *out-of-network providers*.

For each *deductible* amount (in-network and out-of-network) that may apply to this *coverage*, two *deductible* amounts may apply: an individual *deductible* and a family *deductible*. Each *member* must satisfy the individual *deductible* applicable to this *coverage* every *benefit period* before *benefits* are paid. Once the family *deductible* has been met, *benefits* will be paid for a family *member* regardless of whether that family *member* has met his/her individual *deductible*. In calculating the family *deductible*, we will apply the amounts satisfied by each *member* towards the *member's* individual *deductible*. However, the amounts paid by each *member* that count towards the family *deductible* are limited to the amount of each *member's* individual *deductible*.

You should refer to the **Summary of Cost Sharing and Benefits** section to determine if any *deductibles* apply to your *coverage*.

Copayment

A *copayment* is a fixed dollar amount that you must pay directly to the *provider* for certain *benefits* at the time of services. *Copayment* amounts may vary, depending on the type of service for which *benefits* are being provided and/or the type of *provider* performing the service.

You should refer to the **Summary of Cost Sharing and Benefits** section to determine if any *copayments* apply to your *coverage*.

Coinsurance

Coinsurance is the percentage of the *allowable amount* payable for a *benefit* that you are obligated to pay. Depending on your *coverage*, the *coinsurance* may be calculated as two separate percentages: one for *benefits* received for services provided by *in-network providers*; and one for *benefits* for services provided by *out-of-network providers*.

A claim for an *out-of-network provider* is calculated differently than a claim for an *in-network provider*.

You should refer to the **Summary of Cost Sharing and Benefits** section to determine if *coinsurance* applies to your *coverage*.

Benefit Period Program Maximum

A *benefit period program maximum* is the limit of *coverage* placed on a specific *benefit(s)* provided under this *coverage* within a *benefit period*. Such limits on *benefits* are generally in the form of dollar limits.

You should refer to the **Summary of Cost Sharing and Benefits** section to determine if any *benefit period maximums* apply to your *coverage*.

Benefit Lifetime Maximum

A *benefit lifetime maximum* is the maximum amount for a specific *benefit(s)* payable by us during the duration of your *coverage* under the *group contract* or other *group contracts* from the Capital Blue Cross family of companies.

You should refer to the **Summary of Cost Sharing and Benefits** section to determine if any *benefit lifetime maximums* apply to your *coverage*.

Balance Billing Charges

Providers have an amount that they bill for the services or supplies furnished to *members*. This amount is called the *provider's* billed charge. There may be a difference between the *provider's* billed charge and the *allowable amount*, which we pay for *benefits* provided under your *coverage*.

How the interaction between the *allowable amount* and the *provider's* billed charge affects the payment for *benefits* and the amount you will be responsible for paying a *provider* varies depending on whether the *provider* is an *in-network provider* or an *out-of-network provider*.

- For *in-network providers*, the *allowable amount* for a *benefit* is set by the *provider's* contract with us. These contracts also include language whereby the *provider* agrees to accept the amount paid by us, minus any *cost-sharing amount* due from you, as payment in full.

- For *out-of-network providers*, the *allowable amount* for a *benefit* determines the maximum amount we will pay you for *benefits*. Since the *out-of-network provider* does not have a contract with us, the *provider* has not agreed to accept the *allowable amount* as payment in full. The *allowable amount* in these situations can be less than the *provider's* charge. Therefore, you are responsible for paying the difference between the *provider's* billed charge and the *allowable amount* in addition to any applicable *cost sharing amount*. Unless otherwise agreed to by us, or required by law, we will pay you for services performed by an *out-of-network provider*. You are responsible for paying the *provider*.

SCHEDULE OF LIMITATIONS

In addition to the exclusions listed in the **Schedule of Exclusions** section, the *benefits* provided under your dental *coverage* have the following limitations:

1. X-rays:
    a. Periapical X-rays – as required.
    b. Bitewing X-rays – two times per calendar year.
    c. Full Mouth or Panoramic X-ray – one time in three years.
2. Oral Evaluation:
    a. Periodic – two of these services per calendar year; Comprehensive – one of these services per 36 months. Once paid, comprehensive evaluations are not eligible in the same office unless there is a significant change in health conditions or the patient is absent from the office for two or more years.
    b. Limited problem focused and consultations – one of these services per *dentist* per patient per calendar year
    c. Detailed problem focused – one per *dentist* per patient per lifetime per eligible diagnosis
3. Prophylaxis – two per calendar year, Pregnant women allowed 1 additional prophylaxis per calendar year.
4. Fluoride *treatment* – two per calendar year dependent children to age 19
5. One application of caries arresting medicament per primary tooth is covered per lifetime.
6. Space maintainers – dependent children to age 14.
7. Sealants – one per three years per tooth for dependent children to age 14 on permanent first and second molars.
8. Periodontal Services:
    a. Periodontal maintenance – within 24 months from the date of service for periodontal *treatment*, such as periodontal surgery, root scaling and planing.
    b. Surgical periodontal procedures – one per five years, per quadrant.
9. Replacement of restorative services only when they are not, and cannot be made, serviceable:
    a. Amalgam and composite fillings per tooth, per surface every 24 months
10. Denture relining, rebasing or adjustments are considered part of the denture charges. Prosthodontic appliances and abutment crowns will be replaced only after five years.
11. Implants – one per five years. Implant removal is limited to once for each tooth during the *member's* lifetime.

12. Optional *Treatment* Plans: In cases in which there are optional plans of *treatment* carrying different *treatment* costs, payment will be made only for the applicable percentage of the least costly course of *treatment*, so long as such *treatment* will restore the oral condition in a professionally accepted manner. The balance of the *treatment* cost will be your responsibility.

13. Ortho Treatment – Limited to devices and procedures for the correction of malposed teeth of dependent children to age 19, through completion of the procedures' or to the date coverage terminates, whichever occurs first. We will cease to make payment for orthodontic treatment upon termination of treatment for any reason, prior to completion of the procedure.

    Unless otherwise specified in this *Benefits Booklet,* we will pay half of its orthodontic *allowable amount* up front, at the time of banding. The remaining half will be paid one year later. If the treatment time is 12 months or less, our orthodontic payment will be paid as a lump sum at the beginning of the orthodontic treatment. If treatment begins prior to the *member* becoming eligible with us, any payments made by a previous dental carrier will be applied to your orthodontic lifetime maximum.

SCHEDULE OF EXCLUSIONS

Except as specifically provided in this *Benefits Booklet*, we will not provide *benefits* under your dental *coverage* for the following services, supplies, or charges:

1. *Services* or supplies which are provided by any federal or state government agency except Medicaid, or by any municipality, county, or other political subdivision.
2. *Services* that are the responsibility of Workers' Compensation or employer's liability insurance, or for *treatment* of any automobile-related injury.
3. Charges for which *benefits* or *services* are provided to you by any hospital, medical or dental service corporation, any group insurance, franchise, or other prepayment plan for which an employer, union, trust or association makes contributions or payroll deductions (unless the coordination of benefit provisions provide otherwise).
4. *Services* provided or supplies furnished or devices started prior to your *effective date of coverage*.
5. *Treatment* or supplies which you would have no legal obligation to pay.
6. *Treatment* or supplies with respect to congenital malformations.
7. *Treatment* or devices that increase the vertical dimension of an occlusion, restore an occlusion to normal, replace tooth structure lost by attrition or erosion, or otherwise.
8. Preventive plaque control programs, including oral hygiene programs.
9. Periodontal splinting, equilibration and gnathological recordings.
10. Myofunctional therapy.
11. Temporomandibular joint dysfunction.
12. Replacement or repair of lost, stolen, or damaged prosthetic or orthodontic appliances.
13. Prescription drugs, pre-medication, analgesias, and local anesthetics.
14. General anesthesia, except as provided for in this *Benefits Booklet*.
15. *Investigational* procedures.
16. *Treatment* or supplies primarily for *cosmetic* purposes.
17. Elective procedures.
18. Charges for hospitalization or any other surgical treatment facility.
19. *Services* incurred after your termination date of *coverage* except as provided for in this *Benefits Booklet*.
20. *Services* received by you in a country with which United States law prohibits transactions.
21. Charge that exceed the *allowable amount.*
22. *Cost sharing amounts* you must pay as outlined in this *Benefits Booklet*.

23. Travel expenses incurred in conjunction with *benefits*.
24. Court ordered *services* when not dentally necessary and/or not a covered *benefit*.
25. Any *services* rendered while in custody of, or incarcerated by any federal, state, territorial, or municipal agency or body, even if the services are provided outside of any such custodial or incarcerating facility or building, unless payment is required under law.
26. *Services* not billed by an eligible *provider.*
27. Dental *services* rendered by a *provider* who is a *member* of your *immediate family*.
28. Charges for failure to keep a scheduled appointment with a *provider*, for completion of a claim or insurance form, for obtaining copies of dental records, or for your decision to cancel a dental procedure.
29. Any other *service* or *treatment*, except as provided in this *Benefits Booklet*.

UTILIZATION MANAGEMENT

Pre-Treatment Estimates

If you are unsure of the *benefits* for a specific course of *treatment*, or if *treatment* costs are expected to exceed $300, we recommend a *pre-treatment estimate*. You should ask the treating *provider* to submit the claim form in advance of performing the proposed services.

Pre-treatment estimate requests are not required but may be submitted for more complicated and expensive procedures such as crown, wisdom tooth extractions, bridges, dentures, or periodontal surgery. You will receive an estimate of the cost and how much we may pay before *treatment* begins. We will act promptly in returning a *pre-treatment estimate* to you and the treating *provider* with nonbinding verification of the current availability of *benefits* and applicable maximums. The *pre-treatment estimate* is nonbinding as the availability of *benefits* may change subsequent to the date of the estimate due to a change in eligibility status, exhaustion of applicable maximum *benefit* or application of frequency of procedure limitations.

Investigational Treatment Review

Your *coverage* does not include services we determine to be *investigational* as defined in the **Definitions** section.

However, we recognize that situations occur when you elect to pursue *investigational treatment* at your own expense. If you receive a service we consider to be *investigational*, you are solely responsible for payment of these services and the noncovered amount will not be applied to the *deductible*, if applicable.

You or your *provider* may contact us to determine whether we consider a *service investigational*.

Dental Claims Review

We conduct Claims Review through the review of dental records to determine whether the care and services provided and submitted for payment were necessary in accordance with generally accepted dental practice. Review is performed when we receive a claim for payment for services that have already been provided. Claims that require review include, but are not limited to, claims incurred for:

- Inlays, onlays, crowns, prosthodontics, surgical extractions, impactions and implants.
- Gingivectomies, grafts, gingival flap procedures, crown lengthening, guided tissue regeneration and periodontal scaling and root planing.
- Services that are potentially *investigational* or *cosmetic* in nature.

MEMBERSHIP STATUS

To be considered a *subscriber*, child or *dependent* under this *coverage*, an individual must meet certain eligibility requirements and enroll (apply) for *coverage* within a specific timeframe.

There is a limited period of time to submit an *enrollment application* for initial enrollment and enrollment changes. *Subscribers* should consult with the *contract holder* to determine the specific timeframes applicable to them. *Subscribers* who fail to submit an *enrollment application* within these specific timeframes may not be allowed to enroll themselves and/or their newly eligible *dependents* until the next *open enrollment* period. *Subscribers* should refer to the Timelines for Submission of Enrollment Applications section for more details.

Eligibility

Individuals must meet specific eligibility requirements to enroll or to continue being enrolled for *coverage*, unless otherwise approved in writing by us in advance of the *effective date of coverage*.

Nondiscrimination

We will not discriminate against any *subscriber* or *member* in eligibility, continued eligibility or variation in premium amounts by virtue of any of the following: (i) the *subscriber* or *member* taking any action to enforce his/her rights under applicable law; (ii) on the basis of race, color, national origin, disability, sex, gender identity or sexual orientation; or (iii) health status-related factors pertaining to the *subscriber* or *member*. Factors include health status, medical condition, claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability and disability.

Subscriber

An individual must meet all eligibility criteria specified by the *contract holder* and approved by us to enroll in this *coverage* as a *subscriber*. These criteria include meeting all requirements to participate in the *contract holder's* health *benefit* program, including compliance with any probationary or waiting period established by the *contract holder*.

Dependent - Spouse

An individual must be the lawful spouse of the *subscriber* to enroll in this *coverage* as a *dependent* spouse.

We reserve the right to require that a spouse of a *subscriber* provide documentation demonstrating marriage to the *subscriber*, including, but not limited to, marriage certificate, court order or, joint statement of common law marriage as determined by us.

Dependent - Domestic Partner

To enroll in this *coverage* as a *dependent* domestic partner, an individual must be in a relationship with another adult partner of the same or opposite sex, and who live together and share a domestic life, but are not married or joined by a civil union.

We reserve the right to request documentation that demonstrates domestic partnership prior to commencing *coverage* for the domestic partner.

Child

To enroll under this *coverage* as a child, an individual must be under the age of 26 and meet one of the following criteria:

- A birth child of the *subscriber* or the *subscriber's* spouse, or the *subscriber's* domestic partner.
- A child legally adopted by or placed for adoption with the *subscriber* or the *subscriber's* spouse, or the *subscriber's* domestic partner.
- A ward (a child for whom the *subscriber* or the *subscriber's* spouse,, or the *subscriber's* domestic partner has been granted legal custody by a court of competent jurisdiction).
- A child for whom the *subscriber* or the *subscriber's* spouse, or the *subscriber's domestic partner* is required to provide healthcare coverage pursuant to a *Qualified Medical Child Support Order* (QMCSO).

o **Dependent - Child Age 26 or Older with a Disability**

An individual must be an unmarried child age 26 or older to enroll under this *coverage* as a *dependent* child with a disability. The child must meet all of the following criteria:

- A birth child, adopted child, or *ward* of the *subscriber* or the *subscriber's* spouse, or the *subscriber's domestic partner*.
- Mentally or physically incapable of earning a living; or unable to engage in self-sustaining employment by reason of any medically determinable physical or mental impairment(s) which has lasted or can be expected to last for a continuous period of not less than 12 months.
- Chiefly dependent upon the *subscriber* or *subscriber's* spouse, or the *subscriber's domestic partner* for support and maintenance, provided that all the following are true:
  - The incapacity began before age 26.
  - The *subscriber* provides us with proof of incapacity within 31 days after the *dependent* child with a disability reaches age 26.
  - The *subscriber* provides related information as otherwise requested by us, but not more frequently than annually.

Extension of Eligibility for Students on Military Duty

Eligibility to enroll under this *coverage* as a child will be extended, regardless of age, when the child's education program at an accredited educational institution was interrupted due to military duty. In order to be eligible for the extension of eligibility, the child must have been a full time student eligible for health insurance *coverage* under their parent's health insurance policy and either of the following:

- A member of the Pennsylvania National Guard or any reserve component of the armed forces of the United States who was called or ordered to active duty, other than active duty for training, for a period of 30 or more consecutive days; or
- A member of the Pennsylvania National Guard ordered to active State duty, including duty under 35 Pa.C.S. Ch. 76 (relating to Emergency Management Assistance Compact), for a period of 30 or more consecutive days.

The extension of eligibility will apply so long as the child maintains enrollment as a full-time student, and shall be equal to the duration of service on active duty or active State duty.

To qualify for this extension of eligibility the child must submit the following forms to us:

- The form approved by the Pennsylvania Department of Military and Veterans Affairs, which notifies an insurer that the *dependent* has been placed on active duty.
- The form approved by the Pennsylvania Department of Military and Veterans Affairs which notifies an insurer that the *dependent* is no longer on active duty.
- The form approved by the Pennsylvania Department of Military and Veterans Affairs which shows that the *dependent* has reenrolled as a full-time student for the first term or semester starting 60 or more days after the *dependent's* release from active duty.

The above forms can be obtained by contacting the Pennsylvania Department of Military and Veterans Affairs or visiting their website.

Enrollment

When *members* "enroll" with us, they agree to participate in a contract for *benefits* between the *contract holder* and us. All qualified requests to enroll or to change enrollment must be made through the *contract holder*.

Every *member* must complete and submit to *Capital*, through the *contract holder*, an application for *coverage*, which is available from the *contract holder*. Each *member* must also enroll within certain time periods after becoming eligible. These requirements are described in the *group policy*.

Timelines for Submission of Enrollment Applications

There is a limited period of time to submit an *enrollment application* for initial enrollment and enrollment changes. *Subscribers* should consult with the *contract holder* to determine the specific timeframes applicable to their *coverage*.

However, we will only accept from the *contract holder enrollment applications* for initial enrollment or enrollment changes up to 60 days after the *member* is eligible for *coverage* under the *group contract*. Therefore, the *subscriber* should immediately submit an *enrollment application* to the *contract holder* to allow the *contract holder* ample time to submit the *enrollment application* to us.

Subscribers who fail to submit an *enrollment application* within these specific timeframes may not be allowed to enroll themselves and/or their newly eligible *dependents* until the next *open enrollment* period.

Initial Enrollment

"Initial" is the term used to represent eligible *members* enrolling for *coverage* with us for the first time. The initial *group enrollment period* is during the time-period designated by the *contract holder*. *Members* should refer to the sections below for more information on eligibility outside of the initial *group enrollment period*.

Newly Eligible Members

Eligible *subscribers* and *dependents* may enroll for *coverage* when they first meet the appropriate requirements described in the **Eligibility** section. This may occur during the initial *group enrollment period* or at some other time, based on the eligibility rules established by the *contract holder* and us.

Subscriber

A new *subscriber* may enroll with us for *coverage* after becoming eligible, even though a *group enrollment period* is not in progress. *Subscribers* must immediately submit an *enrollment application* through the *contract holder* to ensure that they enroll within the required timeframes. Newly eligible *subscribers* should consult with the *contract holder* to determine the timeframes applicable to their *coverage*. *Members* should refer to the **Timelines for Submission of Enrollment Applications** section for more details.

Dependent - Newborns

An eligible newborn **must** be enrolled as a *dependent* under the *group contract* or enrolled under a separate contract to have *coverage*. If the newborn child qualifies as a *dependent*, under the *group contract*, you must notify the *contract holder* immediately and application must be made through the *contract holder* within the required timeframes to add the newborn child as a *dependent*. *Subscribers* should consult with the *contract holder* to determine the timeframes applicable to enrolling a newborn as a *dependent*. Refer to the **Timelines for Submission of Enrollment Applications** section for more details.

If the newborn child does not qualify as a *dependent*, the newborn child may be converted to an individual contract under the terms and conditions described in the **Continuation of Coverage after Termination** section.

Life Status Change

An individual who does not enroll when first eligible must wait until the next *group enrollment period*. However, individuals who experience a life status change may enroll in *coverage* as a new *subscriber* or *dependent* even though a *group enrollment period* is not in progress. A life status change is an event based on, but not limited to the following:

- A change in job status.
- A change in marital status.
- A change in domestic partnership
- The birth, adoption or placement for adoption of a child.
- Acquiring a stepchild or becoming a legal guardian for a child.
- A court order.
- A change in Medicare status.
- A change in the status of other insurance.

- Loss of other minimum essential *coverage*, including but not limited to, a loss due to termination of employment or reduction in hours, divorce or legal separation, relocation outside our *service area*, or a child ceasing to be eligible for *coverage* under the *group contract.*

If one of these events occurs, you must notify the *contract holder* immediately. To enroll with us for *coverage*, *members* must enroll within the required timeframe after the date of the applicable event noted above (or in the case of a ward for a child, the date specified in the legal custody order).

The *subscriber* must submit an *enrollment application* through the *contract holder* within the required timeframes after the newly eligible *dependent* becomes eligible for *coverage* under the *group contract*. *Subscribers* should consult with the *contract holder* to determine the timeframes applicable to enrolling newly eligible *dependents*. Refer to the **Timelines for Submission of Enrollment Applications** section for more details.

Group Enrollment Period

During a *group enrollment period*, you have the opportunity to make healthcare *coverage* changes, if applicable, and to add eligible *dependents* previously not enrolled. A *group enrollment period* occurs at least once annually.

Effective Date of Coverage

Initial and Newly Eligible Members

Coverage for initial and newly eligible *members* are effective as of the date specified by the *contract holder* and approved by us. *Members* should contact the *contract holder* for details regarding specific *effective dates of coverage*. These requirements are also described in the *group policy*.

Life Status

Individuals who enroll within the required timeframes are covered as of the following dates, as applicable:

- The date of birth, adoption or placement for adoption.
- The date specified in the legal custody order, in the case of a *ward.*
- The date of marriage.
- The date of attaining eligibility as a domestic partner.
- First date after loss of other health insurance coverage.
- First day of the month following enrollment after an individual loses other minimum essential coverage.

Except as set forth above, *coverage* will begin the first day of the first calendar month beginning after the date we receive the request for enrollment following a life status change.

TERMINATION OF COVERAGE

This section explains when and why your *coverage* with us may end.

Termination of Group Contract

When the *group contract* ends, it automatically terminates *coverage* for all *members* in that group. The terms and conditions related to the termination and renewal of the *group contract* are described in the *group contract*, a copy of which is available for inspection at the office of the *contract holder* during regular business hours.

Termination of Coverage for Members

You cannot be terminated based on health status, healthcare need, or the use of *Capital's* adverse *benefit* determination appeal procedures.

However, there are situations where a *member's coverage* is terminated even though the *group contract* is still in effect. These situations include, but are not limited to the following:

- *Subscriber* - *Coverage* ends on the date in which a *subscriber* is no longer employed by, or a *member* of, the company or organization sponsoring this *coverage*. When *coverage* of a *subscriber* is terminated, *coverage* for all of the *subscriber's dependents* is also terminated.
- *Dependent* Spouse - *Coverage* of a *dependent* spouse ends on the date in which the *dependent* spouse ceases to be eligible under this *coverage*.
- *Dependent* Domestic Partner - *Coverage* of a *dependent* domestic partner ends on the date in which the *dependent* domestic partner ceases to be eligible under this *coverage.*
- Child - *Coverage* of a child ends on the date in which the child is no longer eligible as described in the **Enrollment** section. However, *coverage* of a child may continue as a *dependent* child age 26 or older with a disability as described in the **Membership Status** section.
- *Dependent* Child Age 26 or Older with a Disability - *Coverage* of a *dependent* child age 26 or older with a disability ends when the *subscriber* does not submit to us, through the *contract holder*, the appropriate information as described in the **Membership Status** section. The *subscriber* must notify us of a change in status regarding a *dependent* child with a disability.

In addition, *coverage* terminates for *members* if they participate in fraudulent behavior or intentionally misrepresent material facts, including but not limited to the following:

- Using an *ID card* to obtain goods or services:
  - Not prescribed or ordered for the *subscriber* or the *subscriber's dependents.*
  - To which the *subscriber* or the *subscriber's dependents* are otherwise not legally entitled.
- Allowing any other person to use an *ID card* to obtain *services*. If a *dependent* allows any other person to use an *ID card* to obtain *services*, *coverage* of the *dependent* who allowed the misuse of the *ID card* is terminated.

- Knowingly, misrepresenting or giving false information, or making false statements that materially affect either the acceptance of risk or the hazard assumed by us, on any *enrollment application* form.

The actual termination date is the date specified by the *contract holder* and approved by us. *Members* should check with the *contract holder* for details regarding specific termination dates. Except as provided for in this *Benefits Booklet*, if a *member's benefits* under this *coverage* are terminated under this section, all rights to receive *benefits* cease at 11:59:59 PM, local Harrisburg, Pennsylvania time, on the date of termination.

CONTINUATION OF COVERAGE AFTER TERMINATION

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) Coverage

COBRA is a federal law, which requires that, under certain circumstances, the *contract holder* give the *subscriber* and the *subscriber's dependents* the option to continue under this *coverage* with us.

Members should contact the *contract holder* if they have any questions about eligibility for COBRA coverage. The *contract holder* is responsible for the administration of COBRA coverage.

CLAIMS REIMBURSEMENT

Claims and How They Work

To receive payment for *benefits* under your *coverage,* a claim for *benefits* must be submitted to us. The claim is based upon the itemized statement of charges for dental services and/or supplies provided by a *provider*. After receiving the claim, we will process the request and determine if the services and/or supplies provided under this *coverage* are *benefits* provided by your *coverage*, and if applicable, make payment on the claim. The method by which we receive a claim for *benefits* is dependent upon the type of *provider* from which you receive *services*. *Providers* that are excluded or debarred from governmental plans are not eligible for payment by us.

In-Network providers

When you receive services from an *in-network provider*, show your *ID card* to the *provider*. The *in-network provider* will submit a claim for *benefits* directly to us. You will not need to submit a claim. Payment for *benefits* – after applicable *cost sharing amounts*, if any, are deducted - is made directly to the *in-network provider*.

Out-of-Network providers

If you visit an *out-of-network provider*, you may be required to pay for the service at the time it is rendered. Although many *out-of-network providers* file claims on behalf of our *members*, they are not required to do so. Therefore, you need to be prepared to submit your claim to us for reimbursement. Unless you authorize payment directly to the *out-of-network provider*, payment for services provided by *out-of-network providers* is made directly to the *subscriber*. It is then the *subscriber's* responsibility to pay the *out-of-network provider*, if payment has not already been made.

Allowable amount

The *benefit* payment amount is based on the *allowable amount* on the date the service is rendered or on the date the expense is deemed incurred by us.

An eligible expense is considered incurred on the following dates:

- Dentures – on the date the final impression is taken.
- Fixed Bridges, crowns, inlays and onlays – on the date the teeth are initially prepared.
- Root canal therapy – on the date the pulp chamber is opened.
- Periodontal surgery – on the date surgery is performed.
- Implants – on the date the implant is placed.
- All other services – on the date the service is performed.

Filing A Claim

We do not require any special dental claim form. Most dental offices have standard claim forms available. *In-network providers* will fill out and submit the claims. Some *out-of-network providers* may also provide this service upon request. If you receive services from an *out-of-network provider* who does not provide this service, you can submit your own claim directly to us at the mailing address listed below. A separate claim form must be completed for each *member* who received dental services. For your convenience, you can print a claim form from our website at CapitalBlueCross.com.

Dental Service Center
P.O. Box 211424
Eagan, MN 55121

You must also provide additional information, if applicable, including but not limited to, other insurance payment information. If you need help submitting a dental claim, you can contact Member Services at **1-800-613-2624**.

In order to determine if the services are *benefits* covered under this *coverage*, you (or the *provider* on behalf of you) may need to submit dental records, *provider* notes, or *treatment* plans. We will contact you and/or the *provider* if additional information is needed.

Out-of-Country Claims

When you receive dental services outside of the United States, you must pay for the *treatment* at the time of service, get a detailed receipt from the treating *provider*, and then submit the claim to us.

In addition to providing the *provider's* name and address (including country), the receipt should describe the services performed by the *provider* and indicate the tooth or teeth that were treated. It should also indicate whether the *provider's* charges were billed in U.S. dollars or another currency.

Reimbursement is subject to the terms and conditions of your dental *coverage*, and is based on the out-of-network *benefit* provided by your *coverage* under the *group contract*.

Claim Filing and Processing Time Frames

Time Frames for Submitting Dental Claims

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

Time Frames Applicable to Dental Claims

If your claim involves a dental service or supply that was already received, we will process the claim within 30 days of receiving the claim. We may extend the 30-day time period one time for up to 15 days for circumstances beyond our control. We will notify you prior to the expiration of the original time period if we need an extension. We may also mutually agree to an extension if either of us requires additional time to obtain information needed to process the claim.

Coordination of Benefits (COB)

The coordination of *benefits* provision applies when a person has healthcare *coverage* under more than one Plan as defined below.

The order of benefit determination rules govern the order in which each Plan pays a claim for *benefits*.

- The Plan that pays first is the "Primary Plan." The Primary Plan must pay *benefits* in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- The Plan that pays after the Primary Plan is the "Secondary Plan." The Secondary Plan may reduce the *benefits* it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions Unique to Coordination of Benefits

In addition to the defined terms in the **Definitions** section, the following definitions apply to this provision:

Plan: Plan means This Coverage and/or Other Plan.

Other Plan: Other Plan means any individual coverage or group arrangement providing healthcare *benefits* or *services* through any of the following:

1. Individual, group, blanket or franchise insurance coverage except that it shall not mean any blanket student accident *coverage* or hospital indemnity plan of $100 or less;
2. Blue Cross, Blue Shield, group practice, individual practice, and other prepayment *coverage*;
3. *Coverage* under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; and
4. *Coverage* under any tax-supported or any government program to the extent permitted by law.

Other Plan shall be applied separately with respect to each arrangement for *benefits* or *services* and separately with respect to that portion of any arrangement, which reserves the right to take *benefits* or *services* of Other Plans into consideration in determining its *benefits* and that portion which does not.

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

Order of Benefit Determination Rule: The order of benefit determination rules determine whether This Coverage is a Primary Plan or Secondary Plan when you have healthcare *coverage* under more than one Plan.

Primary Plan: The Plan that typically determines payment for its *benefits* first before those of any other Plan without considering any other Plan's benefits.

Secondary Plan: The Plan that typically determines its *benefits* after those of another Plan and may reduce the *benefits* it pays so that all Plan *benefits* do not exceed 100 percent of the total Allowable Expense deemed customary and reasonable by *Capital*.

Covered Service: A service or supply specified in This Coverage for which *benefits* will be provided when rendered by a *provider* to the extent that such item is not covered completely under the Other Plan.

When *benefits* are provided in the form of services, the reasonable cash value of each service shall be deemed the *benefit*.

NOTE: When *benefits* are reduced under the primary contract because you do not comply with the provisions of the Other Plan, the amount of such reduction will not be considered an Allowable Expense under This Coverage.

We will not be required to determine the existence of any Other Plan, or amount of *benefits* payable under any Other Plan, except This Coverage.

The payment of *benefits* under This Coverage shall be affected by the *benefits* that would be payable under Other Plans only to the extent that we are furnished with information regarding Other Plans by the *contract holder* or *subscriber* or any other organization or person.

Allowable Expense: Allowable expense is a healthcare expense, including *deductibles*, *coinsurance*, and *copayments*, that is covered at least in part by any Plan covering the *member*. When a Plan provides *benefits* in the form of *services*, the reasonable cash value of each *service* will be considered an Allowable Expense and a *benefit* paid. An expense that is not covered by any Plan covering you is not an Allowable Expense. In addition, any expense that a *provider* by law or in accordance with a contractual agreement is prohibited from charging a *member* is not an Allowable Expense.

Examples of expenses that are not Allowable Expenses include, but are not limited to the following:

- Any amount in excess of the highest reimbursement amount for a specific *benefit* when two or more Plans that calculate *benefit* payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology cover the *member*.
- Any amount in excess of the highest of the negotiated fees when two or more Plans that provide *benefits* or *services* on the basis of negotiated fees cover the *member*.
- If the *member* is covered by one Plan that calculates its *benefits* or *services* on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology covers a person and another Plan that provides its *benefits* or *services* on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the *provider* has contracted with the Secondary Plan to provide the *benefit* or *service* for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the *provider's* contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its *benefits*.
- The amount of any benefit reduction by the Primary Plan because the *member* has failed to comply with the Plan provisions.

Closed Panel: Closed panel plan is a Plan that provides healthcare *benefits* to covered persons primarily in the form of services through a panel of *providers* that have contracted with or are employed by the Plan, and that excludes *coverage* for services provided by other *providers*, except in cases of emergency or referral by a panel member. An HMO is an example of a closed panel plan.

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

Dependent: A dependent means, for any Other Plan, any person who qualifies as a dependent under that plan.

Order of Benefit Determination Rules

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

1. The Primary Plan pays or provides its *benefits* according to its terms of *coverage* and without regard to the *benefits* under any other Plan..
2. A Plan that does not have a coordination of *benefits* provision as described in this section is always the Primary Plan unless both Plans state that the Plan with a coordination of *benefits* provision is primary.
3. A Plan may consider the *benefits* paid or provided by another Plan in calculating payment of its *benefits* only when it is secondary to that other Plan.
4. Each Plan determines its order of *benefits* using the first of the following rules that apply:

   a. <u>Nondependent or Dependent.</u>

      (i) The Plan that covers the *member* as an employee, policyholder, *subscriber* or *retiree* is the Primary Plan. The Plan that covers the *member* as a Dependent is the Secondary Plan.

   b. <u>Child Covered Under More Than One Plan.</u>

      (i) Unless there is a court decree stating otherwise, when a child is covered by more than one Plan, the order of *benefits* is determined as follows:

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

      - The Plan of the parent whose birthday falls earlier in the calendar year is the primary Plan. This is known as the Birthday Rule; or
      - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan; or
      - If one of the Plans does not follow the Birthday Rule, then the Plan of the child's father is the Primary Plan. This is known as the Gender Rule.

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

      - If a court decree states that one of the parents is responsible for the child's healthcare expenses or *coverage* and the Plan of that parent has actual knowledge of this decree, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
      - If a court decree states that both parents are responsible for the child's healthcare expenses or *coverage*, the provisions of subparagraph (i) determine the order of *benefits*;
      - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or *coverage* of the child, the provisions of subparagraph (i) determine the order of *benefits*; or

- If there is no court decree allocating responsibility for the child's healthcare expenses or *coverage*, the order of *benefits* for the child is as follows:
  - ◊ The Plan covering the Custodial Parent;
  - ◊ The Plan covering the spouse of the Custodial Parent;
  - ◊ The Plan covering the noncustodial parent; and then
  - ◊ The Plan covering the spouse of the noncustodial parent.

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

c. Active Employee or Retired or Laid-off Employee.

The Plan that covers the *member* as an active employee is the Primary Plan. The Plan covering that same *member* as a retired or laid-off employee is the Secondary Plan. The same would hold true if the *member* is a Dependent of an employee covered by the active, retired or laid-off employee.

If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of *benefits*, this rule is ignored. This rule does not apply if the "Nondependent or Dependent "rule can determine the order of *benefits*.

d. COBRA or State Continuation Coverage.

If a *member* whose *coverage* is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the *member* as an employee, *subscriber* or *retiree* or covering the *member* as a Dependent of an employee, *subscriber* or *retiree* is the Primary Plan. The COBRA or state or other federal continuation *coverage* is the Secondary Plan.

If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of *benefits*, this rule is ignored. This rule does not apply if the "Nondependent or Dependent" rule can determine the order of *benefits*.

e. Longer or Shorter Length of Coverage.

The Plan that covered the *member* as an employee, policyholder, *subscriber* or *retiree* longer (as measured by the effective date of *coverage*) is the Primary Plan and the Plan that covered the *member* the shorter period of time is the Secondary Plan. The status of the *member* must be the same for all Plans for this provision to apply. The same primacy would be true if the *member* is a *dependent* of an employee covered by the Longer or Shorter length of *coverage*.

If the preceding rules do not determine the order of *benefits*, the Allowable Expense is shared equally between the Plans. In addition, This Coverage will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Coverage

When This Coverage is secondary, it may reduce *benefits* so that the total paid or provided by all Plans for a service are not more than the total Allowable Expenses.

In determining the amount to be paid, the Secondary Plan calculates the *benefits* it would have paid in the absence of other *coverage*. That amount is compared to any Allowable Expense unpaid by the Primary Plan. The Secondary Plan may then reduce its payment so that the unpaid Allowable Expense is the considered balance. When combined with the amount paid by the Primary Plan, the total *benefits* paid by all Plans may not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan credits to its *deductible* any amounts it would have otherwise credited to the *deductible*.

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

Right to Receive and Release Needed Information

Certain facts about healthcare *coverage* and services are needed to apply these COB rules and to determine *benefits* payable under This Coverage and other Plans. We may obtain and use the facts it needs to apply these rules and determine *benefits* payable under This Coverage and other Plans covering the *member* claiming *benefits*. We need not tell, or get the consent of, the *member* or any other person to coordinate *benefits*. Each *member* claiming *benefits* under This Coverage must give us any facts needed to apply those rules and determine *benefits* payable.

Failure to complete any forms required by us may result in claims being denied.

Facility of Payment

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

Right of Recovery

If the amount of the payments made by us is more than the amount that should have been paid under this COB provision, we may recover the excess amount. The excess amount may be recovered from one or more of the persons or organization paid or for whom it has paid, or any other person or organization that may be responsible for the *benefits* or services provided for the *member*. The “amount of the payments made” includes the reasonable cash value of any *benefits* provided in the form of *services*.

Third Party Liability/Subrogation

Subrogation is our right to recover the amount we have paid on behalf of a *member* from the party responsible for the *member's* injury or illness.

To the extent permitted by law, a *member* who receives *benefits* related to injuries caused by an act or omission of a third party or who receives *benefits* and/or compensation from a third party for any care or *treatment(s)* regardless of any act or omission, shall be required to reimburse us for the cost of such *benefits* when the *member* receives any amount recovered by suit, settlement, or otherwise for his/her injury, care or *treatment(s)* from any person or organization. The *member* shall not be required to pay us more than any amount recovered from the third party.

In lieu of payment above, and to the extent permitted by law, we may choose to be subrogated to the *member's* rights to receive compensation including, but not limited to, the right to bring suit in the

member's name. Such subrogation shall be limited to the extent of the *benefits* received under the *group contract*. The *member* shall cooperate with us should we exercise our right of subrogation. The *member* shall not take any action or refuse to take any action that would prejudice our rights under this **Third Party Liability/Subrogation** section.

The right of subrogation is not enforceable where prohibited by statute or regulation.

There are three basic categories of medical claims that are included in our subrogation process: third party liability, workers' compensation insurance, and automobile insurance.

Third Party Liability

Third party liability can arise when a third party causes an injury or illness to a *member*. A third party includes, but is not limited to, another person, an organization, or the other party's insurance carrier.

When a *member* receives any amount recovered by suit, settlement or otherwise from a third party for the injury or illness, subrogation entitles us to recover, the amounts already paid by us for claims related to the injury or illness. We do not require reimbursement from the *member* for more than any amount recovered.

Workers' Compensation Insurance

Employers are liable for injuries, illness, or conditions resulting from an on-the-job accident or illness. Workers' compensation insurance is the only insurance available for such occurrences. We deny *coverage* for claims where workers' compensation insurance is required.

If the workers' compensation insurance carrier rejects a claim because the injury was not work-related, we may consider the charges in accordance with the coverage available under the *group contract*. *Benefits* are not available if the workers' compensation carrier rejects a claim for any of the following reasons:

- The employee did not use the *provider* specified by the employer or the workers' compensation carrier.
- The workers' compensation timely filing requirement was not met.
- The employee has entered into a settlement with the employer or workers' compensation carrier to cover future medical expenses.
- For any other reason, as determined by us.

Motor Vehicle Insurance

To the extent *benefits* are payable under any medical expense payment provision (by whatever terminology used, including such *benefits* mandated by law) of any motor vehicle insurance policy, such *benefits* paid by us and provided as a result of an accidental bodily injury arising out of a motor vehicle accident are subject to coordination of benefit rules and subrogation as described in the **Coordination of Benefits (COB)** and **Subrogation** sections.

Assignment of Benefits

Except as otherwise required by applicable law, *members* are not permitted to assign any right, *benefits* or payments for *benefits* under the *group contract* to other *members* or to any other individual or entity. Further, except as required by applicable law, *members* are not permitted to assign their rights to

receive payment or to bring an action to enforce the *group contract*, including, but not limited to, an action based upon a denial of *benefits*.

Payments Made In Error

We reserve the right to recoup from the *member* or *provider*, any payments made in error, whether for a *benefit* or otherwise.

APPEAL PROCEDURES

This section explains your right to appeal a decision we make about the benefits under your dental *coverage*.

To Appeal an Adverse Benefit Determination

An adverse benefit determination is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) under your *coverage* with us for a service:

- Based on a determination of your eligibility to enroll under the *group contract.*
- Resulting from the application of any utilization review, or
- Not provided because it is determined to be *investigational* or not dentally necessary.

If you disagree with an adverse benefit determination with respect to *benefits* available under this *coverage*, you may seek review of the adverse benefit determination by submitting a written appeal within 180 days of receipt of the adverse benefit determination.

Your appeal must be sent to:

Grievances and Appeals
P.O. Box 21522
Eagan, MN 55121-0522

You have the right to submit written comments, documents, records, and other information relating to their claim for *benefits*. You also have the right to receive, upon request and free of charge, copies of all documents, records, and other information related to your adverse benefit determination. A request for information does **not** constitute an appeal. To receive copies of this information, requests must be mailed to:

Grievances and Appeals
P.O. Box 21522
Eagan, MN 55121-0522

If the notice of an adverse benefit determination advises you to submit additional information in order to perfect the claim, then you should make arrangements to submit all requested information if and when you file an appeal. Failure to promptly submit any additional information may result in the denial of your appeal.

The following time frames apply to our review of your appeal. We will notify you of our decision within:

- 60 days of receiving your appeal if the appeal involves a dental claim and you file the appeal after receiving the dental service.
- 30 days of receiving your appeal if the appeal involves a *preauthorization* determination and you file the appeal prior to receiving the dental *service*.

If your *coverage* is an employer-sponsored group plan subject to ERISA (collectively, the Employee Retirement Income Security Act of 1974 and its related regulations, each as amended) and if you remain dissatisfied upon completion of the mandatory appeal process described above, you have the right to bring a civil action under ERISA Section 502(a).

Designating an Individual to Act on Your Behalf

You may designate another individual to act on your behalf in pursuing a *benefit* claim or appeal of an unfavorable *benefit* decision.

To designate an individual to serve as your "authorized representative", you must complete, sign, date, and return a Member Authorization Form. You may request this form from our Member Services department at **1-800-613-2624**.

We communicate with your authorized representative only after we receive the completed, signed, and dated authorization form. Your authorization form will remain in effect until you notify us in writing that the representative is no longer authorized to act on your behalf, or until you designate a different individual to act as your authorized representative.

GENERAL PROVISIONS

Discounts and Incentives

We may also make available to our *members* access to health and wellness related discount or incentive programs. Incentive programs may be available only to targeted populations and may include cash or other incentives.

These discount and incentive programs are not insurance and are not an insurance *benefit* or promise under the *group contract*. *Member* access to these programs is provided by us separately or independently from the *group contract*. There is no additional charge to *members* for accessing these discount and incentive programs. Contact the Plan Administrator for information on these programs.

Benefits are Nontransferable

No person other than a *member* is entitled to receive payment for *benefits* to be furnished by *Capital* under the *group contract*. Such right to payment for *benefits* is not transferable.

Changes

By this *Benefits Booklet*, the *contract holder* makes this *coverage* available to eligible *members*. However, this *Benefits Booklet* shall be subject to amendment, modification, and termination in accordance with any provision hereof or by mutual agreement between us and *contract holder* without the consent or concurrence of the *members*. By electing us or accepting our *benefits*, all *members* legally capable of contracting, and the legal representatives of all *members* incapable of contracting, agree to all terms, conditions, and provisions hereof.

Changes in State or Federal Laws and/or Regulations and/or Court or Administrative Orders

Changes in state or federal law or regulations or changes required by court or administrative order may require *Capital* to change *coverage* for *benefits* and any *cost-sharing amounts*, or otherwise change *coverage* for *benefits* in order to meet new mandated standards. Such changes can occur on the earlier of either the *group contract* renewal date or the date such change is required by law, regulation or court or administrative order.

Capital will provide the *contract holder* with an official notice of change at least 60 days prior to the effective date of any change in *coverage* for *benefits.* However, if such change occurred due to a change in law, regulation or court or administrative order which makes the provision of such notice within 60 days not possible, *Capital* will provide such notice to the *contract holder* as soon as reasonably practicable.

Discretionary Changes by Capital

Capital may change *coverage* for *benefits* and any *cost sharing amounts*, or otherwise change *coverage* upon the renewal of the *group contract*.

Capital will provide the *contract holder* with an official notice of change at least 60 days prior to the effective date of any change in *coverage* for *benefits.*

In the future, should terms and conditions associated with this *coverage* change, updates to these materials will be issued. These updates must be kept with this document to ensure the *member's* reference materials are complete and accurate.

Notwithstanding the above, changes in *Capital's* administrative procedures, including but not limited to changes in policy or underwriting guidelines, are not *benefit* changes and are, therefore, not subject to these notice requirements.

Conformity With Statutes

The parties recognize that the *group contract* at all times is subject to applicable federal, state and local law. The parties further recognize that the *group contract* is subject to amendments in such laws and regulations, and new legislation.

Any provisions of law that invalidate or otherwise are inconsistent with the terms of this *coverage* or that would cause one or both of the parties to be in violation of the law, is deemed to have superseded the terms of this *coverage*; provided that the parties exercise their best efforts to accommodate the terms and intent of the *group contract* consistent with the requirements of law.

In the event that any provision of the *group contract* is rendered invalid or unenforceable by law, or by a regulation, or declared null and void by any court of competent jurisdiction, the remainder of the provisions of the *group contract* remain in full force and effect.

Choice of Forum

The *contract holder* and *members* hereby irrevocably consent and submit to the jurisdiction of the federal and state courts within Dauphin County, Pennsylvania and waive any objection based on venue or forum non conveniens with respect to any action instituted therein arising under the *group contract* whether now existing or hereafter and whether in contract, tort, equity, or otherwise.

Choice of Law

All issues and questions concerning the construction, validity, enforcement, and interpretation of the *group contract* is governed by, and construed in accordance with, the laws of the Commonwealth of Pennsylvania, without giving effect to any choice of law or conflict of law rules or provisions, other than those of the federal government of the United States of America, that would cause the application of the laws of any jurisdiction other than the Commonwealth of Pennsylvania.

Choice of Provider

The choice of a *provider* is solely the *member's*. *Capital* does not furnish *benefits* but only makes payment for *benefits* received by *members*. *Capital* is not liable for any act or omission of any *provider*. *Capital* has no responsibility for a *provider's* failure or refusal to render *benefits* or services to a *member*. The use or nonuse of an adjective such as in-network or out-of-network in describing any *provider* is not a statement as to the ability, cost or quality of the *provider*.

Capital cannot guarantee continued access during the term of the *member's* enrollment to a particular *provider*. If the *member's provider* ceases to be in-network, *Capital* will provide access to other *providers* with similar training and experience.

Clerical Error

Clerical error, whether of the *contract holder* or *Capital*, in keeping any record pertaining to the *coverage* hereunder, will not invalidate *coverage* otherwise validly in force or continue *coverage* otherwise validly terminated.

Entire Contract

The *group contract* sets forth the terms and conditions of *coverage* of *benefits* under a Pennsylvania Preferred Provider Organization ("PPO") that is underwritten by *Capital* and offered to *subscribers* and their *dependents* due to the *subscriber's* relationship with the *contract holder*. The *group contract* (including all of its attachments) and any riders or amendments to the *group contract* constitute the entire contract of insurance between the *contract holder* and *Capital*. The *group contract* is made up of four different documents: the *group policy/contract,* the *group application,* the *enrollment applications*, and this *Benefits Booklet*. If there is a conflict of terms between the *group policy/contract* and the *Benefits Booklet*, the terms of the *group policy/contract* shall control and be enforceable over the terms of the *Benefits Booklet*.

Exhaust Administrative Remedies First

Neither the *contract holder* nor any *member* may bring a cause of action in a court or other governmental tribunal (including, but not limited to, a Magisterial District Justice hearing) unless and until all administrative remedies described in the *group contract* have first been exhausted.

Failure to Enforce

The failure of either *Capital*, the *contract holder*, or a *member* to enforce any provision of the *group contract* shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of the *group contract* shall not be deemed or construed to be a waiver of such default.

Failure to Perform Due to Acts Beyond Capital's Control

The obligations of *Capital* under the *group contract* including this *Benefits Booklet* shall be suspended to the extent that *Capital* is hindered or prevented from complying with the terms of the *group contract* because of labor disturbances (including strikes or lockouts); acts of war; acts of terrorism, vandalism, or other aggression; acts of God; fires, storms, accidents, governmental regulations, impracticability of performance or any other cause whatsoever beyond its control. In addition, *Capital's* failure to perform under the *group contract* shall be excused and shall not be cause for termination if such failure to perform is due to the *contract holder* undertaking actions or activities or failing to undertake actions or activities so that *Capital* is or would be prohibited from the due observance or performance of any material covenant, condition, or agreement contained in the *group contract.*

Gender

The use of any gender herein shall be deemed to include the other gender, and, whenever appropriate, the use of the singular herein shall be deemed to include the plural (and vice versa).

ID Cards

Capital provides *ID cards* to all *subscribers* and other *members* as appropriate. For purposes of identification and specific *coverage* information, an *ID card* must be presented when service is requested.

ID cards are the property of *Capital* and should be destroyed when a *member* no longer has *coverage*. Upon request, *ID cards* must be returned to *Capital* within 31 days of the end of a *member's coverage*. *ID cards* are for purposes of identification only and do not guarantee eligibility to receive *benefits*.

Legal Action

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Notwithstanding the foregoing, *Capital* does not waive or otherwise modify any defense, including the defense of the statute of limitations, applicable to the type or theory of action or to the relief being sought, including but not limited to the statute of limitations applicable to actions in tort.

Notices

Any and all notices under the *group contract* shall be given in writing and addressed as follows:

- If to a *member*: to the latest electronic and/or physical address reflected in *Capital's* records.
- If to the *contract holder*: to the latest electronic and/or physical address provided by the *contract holder* to *Capital*.
- If to *Capital* to: PO Box 772132, Harrisburg, PA 17177-2132.

Member's Payment Obligations

A *member* has only those rights and privileges specifically provided in the *group contract*. Subject to the provisions of the *group contract*, a *member* is responsible for payment of any amount due to a *provider* in excess of the *benefit* amount paid by *Capital*. If requested by the *provider*, a *member* is responsible for payment of *cost sharing amounts* at the time service is rendered.

Payments

Capital is authorized by the *member* to make payments directly to *in-network providers* furnishing services for which *benefits* are provided under the *group contract*. In addition, *Capital* is authorized by the *member* to make payments directly to a state or federal governmental agency or its designee whenever *Capital* is required by law or regulation to make payment to such entity.

Once a *provider* renders services, *Capital* will not honor *member* requests not to pay claims submitted by the *provider*. *Capital* will have no liability to any person because of its rejection of the request.

Payment of *benefits* is specifically conditioned on the *member's* compliance with the terms of the *group contract*.

Policies and Procedures

Capital may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this *Benefits Booklet*, with which *members* shall comply.

Relationship of Parties

Healthcare *providers* maintain direct relationship with *members* and are solely responsible to *members* for all medical and/or dental services. The relationship between *Capital* and healthcare *providers* (including *dentists*) is an independent contractor relationship. Healthcare *providers* are not agents or

employees of *Capital*, nor is any employee of *Capital* an employee or agent of a healthcare *provider*. *Capital* shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the *member* while receiving care from any healthcare *provider*.

Neither the *contract holder* nor any *member* is an agent or representative of *Capital* and neither is liable for any acts or omissions of *Capital* for the performance of services under the *group contract*.

The *contract holder* is the agent of the *members*, not of *Capital*.

Certain services, including administrative services, relating to the *benefits* provided under the *group contract* may be provided by *Capital* or other companies under contract with *Capital*, Capital Blue Cross, or Keystone Health Plan Central.

Waiver of Liability

Capital shall not be liable for injuries or any other harm or loss resulting from negligence, misfeasance, nonfeasance or malpractice on the part of any *provider*, whether an *in-network provider* or *out-of-network provider*, in the course of providing *benefits* for *members*.

Workers' Compensation

The *group contract* is NOT in lieu of and does not affect any requirement for *coverage* by workers' compensation insurance.

Public Health Emergency

In the event that *Capital* reasonably determines that there is a public health emergency, such as but not limited to, a pandemic or natural disaster, *Capital* may, but is not required to, waive or modify term(s) of the contract related to the application of clinical management programs, *member* cost share, provisions related to the use of an *in-network provider* or pharmacy, or such other terms in order to reduce the cost of or to expedite the provision of care. *Capital* will provide notice of such change as circumstances allow.

Physical Examination

Capital at its own expense shall have the right and opportunity to examine the person of the *member* when and as often as it may reasonably require during the pendency of a claim.

Applicable Group Numbers

00504309 Dental Plan 2

March, 2026