County Health Pool

Dental Plan B
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION OF DENTAL BENEFITS

CTSI
Serving Colorado's Counties

Effective January 1, 2026

County Health Pool
Dental Plan B Benefit Summary

Administered by CTSI

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, exclusions, qualifications, limitations, terms and provisions of the County Health Pool Plan Document and Summary Plan Description. For a covered dental service, this coverage will pay the applicable percentage (shown in the "Coverage Percentage" column) of the dental maximum allowable for that service (subject to the fee schedule) up to the Annual Maximum. Only those expenses incurred as a result of non-occupational injury or illness will be considered eligible expenses. Please contact Anthem customer service at 800-627-0004 service to verify your dental coverage. The County Health Pool Dental Plan Document is available at www.ctsi.org.

Covered Benefits	Plan B Coverage Percentage
Annual Calendar Year Deductible (Single/Family)	$50 / Max of 3 x $50
Annual Calendar Year Maximum	$1,500
Diagnostic and Preventive Services (*no deductible)* Oral evaluations X-rays Cleanings Space maintainers Other selected diagnostic and preventive services	100%
General Services *(deductible applies*) Emergency palliative treatment Consultations Office visits for observation Other selected general services	80%
Restorative Services *(deductible applies)* Amalgam and composite restorations Pin retention procedures	80%
Endodontic Services *(deductible applies)* Root canal therapy Apexification Therapeutic pulpotomy Other selected endodontic services	80%
Oral Surgery Services *(deductible applies*) Simple surgical tooth extractions General anesthesia (surgical procedures) I.V. sedation (surgical procedures) Other selected oral surgery services Note: Some surgical procedures (i.e. surgical extraction of impacted wisdom teeth) will be eligible benefits under the medical plan. Please consult the Plan Document and Summary Plan Description, or contact Customer Service.	80%
Periodontal Services *(deductible applies)* Gingivectomy Crown lengthening Osseous surgery Soft tissue grafts Other selected periodontal services	80%
Prosthodontic Services *(deductible applies*)	Not Covered
Orthodontic Services *(deductible applies*)	Not Covered

Welcome

Welcome to your Dental Benefit Plan. This Plan Document and Summary Plan Description has been prepared to help explain your dental care benefits. Please refer to this Plan Document and Summary Plan Description when you require dental services. It describes how to access dental care, what dental services are covered by the Plan, and what portion of the dental care costs you will be required to pay. County Health Pool (CHP) has contracted with Anthem Blue Cross and Blue Shield (Anthem) to administer this Dental Benefit Plan.

The coverage described in this Plan Document and Summary Plan Description is subject in every respect to the provisions of the Contract issued to County Health Pool. The Contract and this Plan Document and Summary Plan Description and any amendments or riders attached to the same, shall constitute the Contract under which Covered Services and supplies are provided by the Plan.

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

Many words used in the Plan Document and Summary Plan Description have special meanings. These words appear in capitals and are defined for you. Refer to these definitions in the Glossary section for the best understanding of what is being stated. The Plan Document and Summary Plan Description also contains Exclusions.

This Dental Plan Document and Summary Plan Description supersedes and replaces any Dental Plan Document and Summary Plan Description previously issued to you under the provisions of the Contract.

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

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Statement of Enrollee Rights

As an Enrollee in the Plan, an individual is entitled to certain rights including the right to:

- Examine, without charge, at the Plan Administrator's office, all Plan documents.
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- To the extent required or permitted by law, give or withhold consent regarding use and disclosure of protected health information, request privacy of such information and request amendment or correction of such information.
- Expect proper and equitable treatment from the persons who are responsible for the operation of the Plan.

Eligibility

Eligibility

Employee Participants

An Employee is one who works at least 30 hours per week (full-time employment status) directly in the regular business of and is compensated for services by the Member or Member Affiliated Entity. Elected officials, except for non-salaried elected officials and Licensed Professional Elected Officials, are considered Employees under the Plan. At the option of the Member, permanent part-time and/or any other employees that qualify under the Affordable Care Act working a minimum of 24 hours per week, and Licensed Professional Elected Officials may be eligible for coverage; in such case, such qualified part-time Employees and Licensed Professional Elected Officials are considered Employees under the Plan. Also, at the option of the member, employees that are participants in a retirement incentive program provided through the member, and who are between 62 and 65 years of age with a minimum of 5 consecutive years of employment service, may be eligible for coverage; in such case, Incentivized Retirees are considered Employees under the Plan. Incentivized Retirees eligibility for coverage would be limited to coverage starting as early as the month in which they become 62 years of age and ending at the end of the month in which they become 65 years of age. Temporary Employees and retirees are not eligible and cannot be considered for coverage. Eligibility for coverage as an Employee Participant in the Plan begins subsequent to the day a person commences either full-time or qualifying part-time employment, in accordance with individual policies set by Members.

Suspension or denial of eligibility, coverage, and benefits may occur should an Employee Participant fail to do any of the following:

- Pay required contribution, if any, to the Plan.
- Furnish any information, records or releases that the Plan may require in order to adjudicate a claim.
- Cooperate with the procedures and investigations of the Plan.
- Meet the requirements of the Plan Document and Summary Plan Description.
- Meet the definition Employee as stated above.

Employee Participants may be entitled to benefits under the Plan during a family or medical leave in accordance with the provisions of the Family and Medical Leave Act of 1993, as may be amended.

Temporary Employees may be eligible for the plan in accordance with the provisions of the Member's Affordable Care Act Look Back Policy.

Employee Participant's Dependents

Your group may have limited or excluded the eligibility of certain Dependent types and so not all Dependents listed in this Plan may be entitled to enroll. For more specific information, please see your Human Resources or Benefits Department.

An Employee Participant's Dependents may include the following:

- An Employee Participant's legal spouse, common-law spouse (unless legally separated) , civil union same-sex domestic partner
- An Employee Participant's Dependent child (including a step-child, legally adopted or disabled child) under 26 years of age. At the end of the birth month in which the child attains turns age 26, the Dependent child is removed from coverage. If the Subscriber or the Subscriber's Spouse is subject to a qualified medical child support order for a Dependent child of the Subscriber or the Subscriber's Spouse, the Dependent child is eligible for benefits, whether the child lives with the Subscriber or the Subscriber's Spouse. The dependents (spouse or child) of a Dependent child are not eligible for coverage under this Plan Document.
- Coverage may be continued for any unmarried Dependent child after the age of 26 if incapable of self-support because of mental retardation or severe physical handicap, provided such Dependent child became so incapable prior to the end of the month in which the child attained the limiting age and is dependent upon the Employee Participant for care and support. Notification and a Physician's statement certifying such incapacity must be submitted to the Plan within 31 days of the date the Dependent child's coverage would otherwise terminate.

- If both husband and wife are employed by the same Member and are eligible as Employee Participants, either Employee spouse may elect to cover the other Employee spouse as a Dependent together with any eligible children.
- Proof of dependent status or legal guardianship may be requested from time to time by the Plan. This proof may be requested in the form of marriage records, birth certificates, and official court certified adoption, legal guardianship and divorce decree documents. A Power of Attorney will not be accepted as proof of dependency.
- The Employee Participant must notify the Member and the Plan within 31 days after any change in status affecting coverage resulting from marriage, birth, adoption, divorce, legal separation, death, a child reaching age 26, or the entrance into or the return from military service.
- Eligibility for Employee Participants and Dependents is additionally limited to persons who are United States citizens by birth or naturalization, or who are legal aliens lawfully residing in the United States.
-

Employee Participant's Disabled Dependent(s)

Benefits under this Plan for an unmarried Dependent child may be continued if all of the following tests are met:

- The child is incapable of self-sustaining employment because of mental retardation or physical handicap and became so incapacitated prior to such date.
- The child is chiefly dependent on the Employee Participant for support.
- The Member and the Plan are furnished proof of the incapacity not later than 31 days after the date the child attains age 26.

However, benefits as to such child may not be continued beyond the earliest of the following occurrences:

- Cessation of the incapacity.
- Failure to furnish any required proof of continuing incapacity or to submit to any required examination.
- Termination of the child's coverage for any reason other than age.

The Plan has the right to require proof of the continuation of incapacity and the right and opportunity to examine the child as often as is reasonably necessary during the continuation of the incapacity. However, an examination will not be required more often than once a year. The "Mentally or Physically Disabled Dependent Enrollment Request" is available from the Plan or Customer Service and must be completed by a physician with the appropriate medical specialty.

Medicare Eligible Enrollees

The term Medicare refers to the program of medical care benefits provided under Federal Law. Employee Participants and their Dependents age 65 or older are given the option to elect this Plan or Medicare as primary. If the Employee Participant or Dependent elects the benefits of this Plan as primary, this Plan will provide benefits equivalent to the benefits available to individuals not eligible for Medicare. If the Employee Participant or the Dependent elects Medicare benefits as primary, this Plan will not provide benefits complementary to Medicare, and will not coordinate benefits with Medicare. Medicare does not provide dental benefits.

Note: The Enrollee must notify the Plan of election of Medicare as primary and notification must be <u>in writing</u>.

Effective Dates and Contribution Requirements

This Plan Document and Summary Plan Description is effective as of January 1, 2022. Benefits of this Plan shall be payable only for expenses incurred on or after the Effective Day of this Plan Document and Summary Plan Description, and on or after the Effective Date for an Enrollee's coverage, except as specified.

The Effective Date for an Enrollee's coverage under the Plan is determined in accordance with a policy set by the individual Member that employs the prospective Employee Participant. Plan Members have elected whether their individual Employee Participants will contribute to the cost of the Employee Participants' and/or Dependents' coverage.

Benefits for Employee Participants

Coverage for the Employee Participant becomes effective on his eligibility date provided the Employee Participant has enrolled and authorized contributions (if required).

- If the Employee Participant enrolls within 31 days of his eligibility date, coverage will be effective on the date of eligibility.
- If the Employee Participant does not enroll within 31 days of his eligibility date, or coverage is terminated at any time while the Employee Participant is still at work, he is considered to be a Late Enrollee. If he was covered under another plan and loses that coverage, he may be eligible for a Special Enrollment. He may, in the future, be able to enroll himself in this Plan effective January 1 of a re-enrollment year, provided that he requests enrollment prior to January 1 of the year he desires coverage.
- If the Employee Participant does not want coverage, he must sign a waiver of benefits.

Benefits for Dependent Participants

Coverage for Dependent Participants becomes effective on the date eligible provided the Employee Participant has enrolled and authorized contributions (if required) for Dependent benefits on or prior to the date eligible.

- If an Employee Participant has eligible Dependents on the Effective Date of his coverage and he has enrolled and authorized contributions (if required) for Dependent benefits, coverage for those Dependents will be effective on the date the Employee Participant's coverage begins.
- If an Employee Participant, who is not required to contribute toward the cost of Dependent benefits, does not have eligible Dependents on the Effective Date of his coverage and later acquires his first eligible Dependent(s) enrolls his Dependent(s) within 31 days of the date eligible, coverage will be effective on the date of acquisition.
- If an Employee Participant, who is required to contribute toward the cost of Dependent benefits, does not have eligible Dependents on the Effective Date of his coverage and later acquires his first eligible Dependent(s) enrolls his Dependent(s) within 31 days of the date eligible, and authorizes contributions for Dependent benefits to be effective the date of acquisition, coverage will be effective as of the date of acquisition.
- If an Employee Participant, who is required to make a contribution toward the cost of Dependent benefits, and does not have eligible Dependents on the Effective Date of his coverage and later acquires his first eligible Dependent(s) and he enrolls within 31 days of the date eligible, and authorizes contributions for Dependent benefits to be effective the first of the month following acquisition, coverage will be effective on the first of the month following acquisition.
- Dependent benefits with respect to a Dependent acquired by an Employee Participant while he is covered for Dependent benefits shall become effective on the date such Dependent is acquired if he enrolls his Dependent within 31 days.
- If an Employee Participant does not enroll for Dependent benefits within 31 days of the date eligible or Dependent coverage is terminated at any time while the Employee Participant is still at work, his Dependent(s) are considered to be late Enrollee(s). If they are covered under another plan and lose that coverage, they may be eligible for Special Enrollment. The Employee Participant may in the future be able to enroll his Dependent(s) in this Plan effective January 1 of a re-enrollment year, provided that he requests enrollment prior to January 1 of the year they desire coverage.
- In the case of a newborn Dependent, coverage will be retroactive to the date of birth. The first 31 days, the newborn will be covered under the mother's policy, if a covered participant of the plan. To extend coverage for the newborn beyond the first 31 days, the Employee Participant must enroll the newborn within 31 days following the birth.
- In the case of a newborn Dependent, coverage will be retroactive to the date of birth if an Employee Participant enrolls the newborn within 31 days following the birth.
- If the Employee Participant does not want coverage for his eligible Dependents, he must sign a waiver of benefits.
- No Dependent benefits shall become effective unless the Employee Participant is, or simultaneously becomes a Participant covered for benefits.

Enrollment Process

In order for eligible Employee Participants and their eligible Dependents to obtain benefits, the Employee Participant must follow the Member's enrollment process, which details who is eligible for enrollment and what forms are required for enrollment. Eligibility for benefits under this Plan Document and Summary Plan Description begins as of the Effective Date stated on the benefit ID Card. No services received prior to that date are covered.

Note: Submission of an Enrollment Application/Change Form does not guarantee Enrollee enrollment.

Enrollment Forms

The Employee Participant must submit an Enrollment Application/Change Form to add any Dependents as Enrollees. Additional forms may be required for special dependent status. Employee Participants may obtain an Enrollment Application/Change Form or any additional forms from their Benefit Administrator/Contact Person or the Customer Service Department.

Initial Enrollment

Eligible Employees may apply for benefits for themselves and their eligible Dependents by submitting an Enrollment Application/Change Form. The Member and the Plan must receive the Enrollment Application/Change Form within 31 days after the date of hire or within 31 days of the expiration of the waiting period. The Effective Date of benefits will commence on the first of a month, the waiting period is determined in accordance with a policy set by the individual Member that employs the prospective Employee. The Member will inform the Employee of the length of the waiting period or applicable Look Back Period**.**

Open Enrollment

Any eligible Employee may enroll during the Plan's open enrollment period. The Benefit Administrator/Contact Person will provide the dates of the open enrollment period to eligible Employees.

Newly Eligible Dependent Enrollment

A current Employee Participant may add an eligible Dependent, for whom the Employee Participant is legally financially responsible regarding medical, dental, and other health care expenses, that becomes newly eligible due to a Qualifying Event. See the EMPLOYEE PARTICIPANT'S DEPENDENT heading in this section for information on eligibility requirements of a Dependent. Qualifying Events may include marriage, birth, and placement for adoption or issuance of a court order. The Member and the Plan must receive an Enrollment Application/Change Form for the addition of the Dependent within 31 days after the date of the Qualifying Event. Proof of the Qualifying Event, e.g. a copy of the marriage certificate or court order, must be attached to the completed Enrollment Application/Change Form. Eligibility for benefits will be effective as described in the EMPLOYEE PARTICIPANT'S DEPENDENT section.

When the Employee Participant or the Employee Participant's spouse is required by a court or administrative order for child support to provide coverage for an eligible Dependent, the eligible Dependent must be enrolled within 31 days of the issuance of such order. The Member and the Plan must receive a copy of the court or administrative order with the Enrollment Application/Change Form. If the Employee Participant does not enroll the eligible Dependent within 31 days of issuance of the order, the Employee Participant may enroll subject to the provisions described under the heading *Late Entrants* in this section**.**

Special Enrollment for Eligible Employees and Eligible Dependents

If the Employee Participant does not enroll within 31 days of his Eligibility Date, or coverage is terminated at any time while the Employee Participant is still at work, he is considered to be a Late Enrollee unless he was covered under another plan and loses that coverage, in which case he may be eligible for Special Enrollment. He may in the future be able to enroll himself and his Dependents in this Plan during a re-enrollment period.

Status Change of State Medicaid Plan or State Child Health Insurance Program (SCHIP)

Loss of eligibility from a state Medicaid or SCHIP health plan is also a qualifying event for special enrollment for the eligible employee and/or eligible Dependents. The employee must properly file an application with the employer within 60 days after coverage has ended, Medicaid coverage has ended, or 90 days after SCHIP coverage has ended. In addition, special enrollment is allowed for the employee who becomes eligible for premium assistance, with respect to coverage under the employer's health coverage, under a state Medicaid or SCHIP health plan, including any waiver or demonstration project conducted under or in relation to these plans. Similarly, the employee must properly file an application with the employer within 60 days after the eligibility date for assistance is determined.

Termination

Employee Participant Termination

The coverage of any Employee Participant under this Plan shall cease on the earliest of the following:

- The termination date of this Plan Document and Summary Plan Description.
- The ending of the period for which contributions, if required, have been paid.
- The last day of the month the Employee Participant is no longer eligible for coverage under this Plan Document and Summary Plan Description.
- The Employee Participant begins active duty in the Armed Forces of any country for longer than 31 days.
- The death of the Employee Participant.
- The last day of the month in which the employment of the Employee Participant terminates employment.
- The last day of the month in which the Employee Participant retires.
- The last day of the month in which retirement of the Employee Participant occurs, unless covered as an Incentivized Retiree.
- The last day of the month in which an Employee Participant has experienced a Qualifying Event or financial hardship. The Employee has 31 days from the date of the Qualifying Event or financial hardship to notify the Plan Administrator and provide supporting documentation.

A Member must signify an Employee's termination of employment by notifying the Plan. If subsequent to termination of service, an Employee Participant is re-employed or reinstated as an eligible Participant, he will be treated in the same manner as a new Participant at the date of such re-employment or reinstatement unless such Employee Participant has been covered continuously since termination by electing coverage under this Plan through COBRA.

Members may, according to their policies, continue coverage for an Employee Participant on leave of absence or otherwise approved absence from work, at the same contribution level as any other Employee for a period of up to six months without terminating the Employee Participant.

Employee Participants' Dependent Termination

Coverage with respect to any participating Dependent shall cease at the end of the month in which the individual ceases to be a Dependent as defined in this Plan Document and Summary Plan Description. Coverage with respect to all Dependents of an Employee Participant shall cease on the date coverage terminates for the Employee, except as provided in COBRA COVERAGE as defined in this document. An Employee Participant's Dependent coverage shall also terminate at the end of the month the Employee Participant requests such coverage be terminated, but in no event prior to the date of such request.

Effect of Termination

When coverage terminates, benefits shall not be provided for any hospital, medical or dental service after termination even though such services are furnished as a result of a sickness or accident occurring before such termination of coverage unless otherwise provided under this Plan.

Certificate of Creditable Coverage

When an Enrollee's benefits with the Plan terminates, Anthem, on behalf of the Plan, will send the Enrollee a Certificate of Creditable Coverage, which will identify the length of the Enrollee's creditable coverage with the Plan. The Enrollee may need this letter as proof of prior coverage when the Enrollee enrolls with another plan.

What the Plan Will Pay for After Termination

The Plan will not pay for any services provided after the Enrollee's benefits end. An Enrollee is liable for benefit payments made by the Plan on behalf of the Enrollee for services provided after the Enrollee's benefits have terminated, even if the termination was retroactive.

COBRA Coverage

In accordance with Federal Law, under certain circumstances, an Enrollee whose coverage under this Plan would otherwise terminate, may elect to continue coverage for a limited period of time.

An Enrollee who is eligible for COBRA coverage is called a Qualified Beneficiary. The events making an Enrollee eligible for COBRA coverage are called Qualifying Events. Definitions of both terms can be found in the GLOSSARY section.

COBRA Eligibility

Employee Participants and their Dependents who lose eligibility under this Plan are eligible for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Enrollees should contact their Benefit Administrator/Contact Person for additional information. COBRA coverage is available for 18, 29 or 36 months, depending on the Qualifying Event(s), and only if the application and premium of the Federal Law are met.

COBRA coverage is available for Employee Participants and their Dependents for 18 months from the date of the following Qualifying Events:

- When an Employee Participant loses coverage due to a reduction in work hours, including layoffs.
- When an Employee Participant loses coverage due to the voluntary or involuntary termination of employment, including retirement and excluding gross misconduct.

COBRA coverage is available for Employee Participants and their Dependents for 29 months from the date of the following Qualifying Event:

- When the Social Security Administration has determined that an Employee Participant or Dependent was disabled when coverage was terminated, or within 60 days after the coverage was terminated, due to one of the Qualifying Events above, and the Employee Participant or Dependent is still disabled when the 18-month continuation period expires.

COBRA coverage is available for the following individuals for 36 months from the date of the following Qualifying Events:

- The surviving spouse and surviving children of a covered Employee Participant, when the covered Employee Participant dies.
- The Employee Participant became eligible for Medicare benefits prior to COBRA election.
- Spouse or dependent children of a covered employee, if the employee became eligible for Medicare benefits before COBRA election.
- Spouse or dependent children of a covered employee, when the employee and the Spouse separate or divorce.
- Spouses and dependent children of a covered Employee Participant, when the dependent children lose eligibility as Dependents.

COBRA coverage is available to children born or placed for adoption during the period of COBRA coverage for the remainder of either the 18-month or 36-month COBRA continuation period. The Qualifying Event that triggered the COBRA coverage will determine the length of the continuation period for the newborn or adoptee.

COBRA Notification

In the case of a Qualifying Event (death, termination of employment or reduction in hours) a Qualified Beneficiary will receive information from the Plan concerning COBRA Coverage. This information will include instructions on how to elect COBRA, the amount of the monthly COBRA contribution, and enrollment and payment instructions.

With respect to disabled Employees electing the 11-month extension of COBRA, such disabled Employee must notify the Plan within 60 days of determination of disability by Social Security and before the end of the initial 18-month continuation period. In addition, the disabled Employee must notify the Plan within 30 days of final determination of Social Security that the disability no longer exists. Following receipt of timely notice of such Qualifying Event and within 14 days of receipt of loss of coverage, the Plan will provide the disabled Employee with information concerning COBRA coverage and rates.

In the case of a Qualifying Event, or the Employee's enrollment in either Part A or Part B of Medicare, a Qualified Beneficiary must notify the Member and the Plan within sixty (60) days of the Qualifying Event. If notice is not received within 60 days of the Qualifying Event, the Qualified Beneficiary will not be eligible for COBRA Coverage. Following receipt of timely notice of a Qualifying Event and within 14 days of receipt of such notice, the Plan will provide the eligible Dependent with information concerning COBRA coverage and rates.

After notification of COBRA coverage, the Qualified Beneficiary will have 60 days to elect COBRA coverage, after the later of the following dates:

- The date that the Qualified Beneficiary would lose coverage on account of the Qualifying Event,
- The date that the Qualified Beneficiary is sent such notice.
- If a Qualified Beneficiary chooses to waive coverage, a waiver of COBRA coverage will be effective on the date that the waiver is sent to the Plan.
- A Qualified Beneficiary who, during the election period, waives COBRA coverage can revoke the waiver at any time before the end of the election period. However, if a Qualified Beneficiary who waives COBRA coverage later revokes the waiver, coverage will be effective retroactive to the original Qualifying Event date.
- The first monthly payment (which will include premiums for all months since coverage terminated) must be received by the Plan within 45 days of the date the Qualified Beneficiary elects to continue coverage. Each subsequent payment is due by the first day of the month for which coverage is intended, and shall be considered timely if received within 30 days of the date due.
- If premiums are not received in a timely manner, coverage will terminate. No claims will be paid until premium payment is received by the Plan.

Termination of COBRA Coverage

COBRA coverage as provided under this section will terminate on the earliest of the following dates, as applicable:

- The date the Qualified Beneficiary first becomes covered under any other group dental coverage as an Employee or Dependent after COBRA is elected. In the event such other group dental coverage has a pre-existing condition clause or limitation, COBRA coverage will not terminate until exhaustion of the maximum period COBRA coverage is allowed or until the pre-existing condition clause or limitation has been satisfied.
- The end of the period for which the last payment was made for coverage in a timely manner.
- The maximum continuation period has been exhausted.
- The date the Qualified Beneficiary becomes covered by Medicare.
- The date the Member ceases to provide any group health plan.
- The Qualified Beneficiary's coverage was extended due to disability and there has been a final determination that he or she is no longer disabled. In that case, COBRA coverage for all Qualified Beneficiaries who were entitled to the disability extension, by reason of the disability of the Qualified Beneficiary who has been determined to be no longer disabled, will end on the first day of the month that begins no more than 30 days after the date of final determination that the individual is no longer disabled. Such determination will not result in the termination of COBRA coverage before the end of the maximum coverage period that would apply without regard to the disability extension.
- The end of the month for which the Qualified Beneficiary has requested, in writing, a voluntary termination.

Contribution for COBRA Coverage

For a Qualified Beneficiary to continue coverage under this Plan, the entire cost of coverage must be paid to the Plan, each month. The contribution will be 102% (except in the case where COBRA is extended due to disability, the contribution amount will be 150%) of the applicable contribution for a similarly situated non-COBRA Enrollee.

Election Period for COBRA Coverage

A Qualified Beneficiary must elect COBRA coverage within sixty (60) days after the later of:

- The date coverage terminates under this Plan because of the Qualifying Event.
- The date the Qualified Beneficiary receives notice from the Member of the right to this continuation.

Further detail concerning COBRA is available from the Benefit Administrator/Contact Person.

Family and Medical Leave Act

When an Employee Participant takes time off from work pursuant to the Family and Medical Leave Act, dental benefits remain in force but the Employee Participant may be required to pay the Member's share of the contribution. Enrollees may contact their Benefit Administrator/Contact Person for details.

Covered Services

This section describes the Covered Services available under your dental care benefits when provided and billed by Providers. All Covered Services are subject to the Exclusions listed in the Exclusions section. Covered Services must be medically necessary and not Experimental/Investigational.

To receive maximum benefits for Covered Services, you must follow the terms of this Plan Document and Summary Plan Description. Benefits for Covered Services are based on the Maximum Allowable Amount for such service.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Plan Document and Summary Plan Description. Maximum for Covered Services will be limited by any applicable Deductible or annual or lifetime payment limit in the Plan Document and Summary Plan Description, including the Summary of Dental Benefits. The fact that a Dentist or Provider may prescribe, order, recommend or approve a service does not make the service medically necessary or a Covered Service and does not guarantee payment. Anthem, on behalf of the Plan, bases its decisions about Pre-authorization, medical necessity, experimental services and new technology on dental and medical policy developed by Anthem. Anthem, on behalf of the Plan, may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the dental and medical effectiveness of health care services and technology.

The Maximum Allowable Amount for all Covered Services includes the administration of necessary infection control procedures as required by state and federal mandates. If billed separately, such charges will be denied.

Diagnostic and Preventive Services

Diagnostic and preventive services are services that are used to avert dental disease or to determine the nature or cause of a dental disease. Covered Services include examinations, oral evaluations, x-rays, teeth cleaning and scaling, fluoride treatments, sealants, and selected space maintainers, as listed herein.

Oral Evaluation

Limited to two per Calendar Year in any combination of the following types of evaluations: periodic, limited (emergency), comprehensive, detailed, and extensive.

Dental Radiographs (X-rays):

- **Bitewing** radiographs (up to four), limited to once per Calendar Year.
- **Complete series** (panoramic film or full-mouth radiographs), limited to once every three years. Complete series radiographs include bitewings, and will count as one occurrence for that Calendar Year. Nine or more radiographs in any combination of periapical and bitewing radiographs will be considered a complete series.

Note: Benefits are not provided for periapical x-rays when performed on the same date as a complete series or a panoramic film.

Radiographs may be allowed more frequently if requested by the Plan for diagnostic evaluation. The Plan reserves the right to request radiographs and/or diagnostic data from the Provider of service.

Cleaning, Scaling, and Polishing the Teeth (Prophylaxis)

Limited to two per Calendar Year, which can vary in degree of difficulty (see "Periodontal Services" for limitations on periodontal scalings and periodontal maintenance procedures).

Space Maintainers

Dependent children are eligible to receive benefits for space maintainers when used to maintain the space for prematurely lost teeth and only when necessary to prevent future orthodontic care. This benefit is provided only once per lifetime. Space maintainers will be re-cemented only once per lifetime and excludes orthodontics.

Other Diagnostic and Preventive Services

Dependent children are eligible to receive benefits for the following diagnostic and preventive services:

- **Fluoride treatments** (topical application), limited to two per Calendar Year.

- **Sealants**, but only to the unrestored occlusal surface of permanent, posterior (molar) teeth, limited to once per Calendar Year and a lifetime maximum of two applications per tooth.

General Services

Covered Services include limited Emergency care, office visits, consultations, and anesthesia services, as listed below.

- **Palliative (Emergency) Treatment for Dental Pain,** limited to two treatments per Calendar Year (not covered when performed in conjunction with other dental treatment).
- **Consultations,** limited to a lifetime maximum of once per Provider (not covered when performed in conjunction with examinations).
- **Analgesics,** (includes nitrous oxide).
- **General anesthesia,** when administered by a qualified, licensed professional; surgical procedures only. Pre-certification is required for use of general anesthesia when used for a non-surgical procedure.
- **Intravenous sedation,** when administered by a qualified, licensed professional; surgical procedures only. Pre-certification is required for use of intravenous sedation when used for a non-surgical procedure.
- **Office visit for observation,** limited to two visits per Calendar Year (not covered when associated with other services or procedures).

Restorative Services

The process of replacing, by artificial means, a part of a tooth that has been damaged by disease (e.g., cavities). Covered Services include "filling" teeth and preparing teeth for fillings, as listed below.

The following are covered restorative services under this Plan Document and Summary Plan Description:

- **Amalgam restorations,** limited to once per surface per tooth in any Calendar Year.
- **Composite restorations,** limited to once per surface per tooth in any Calendar Year.
- **Pin retention,** limited to once per tooth in any Calendar Year (regardless of the number of pins per tooth). Pin retention must be performed on the same date of service and in conjunction with a covered amalgam or composite restoration.

Endodontic Services

Dental services for the prevention, diagnosis, and treatment of diseases and injuries affecting the dental pulp, tooth root, and periradicular tissue. Covered Services include root canal fillings (filling the roots of teeth) and limited associated services, as listed

Root Canal Therapy

Coverage for root canal therapy includes clinical procedures, postoperative radiographs, and follow-up care (all are included in the total root canal therapy allowance), limited to once per tooth in any three years and to permanent teeth only. A treatment plan is recommended, but not required. Re-treatment of root canal therapy will be covered only if existing root canal therapy is over three years old.

Other Endodontic Services:

The following Covered Services are limited to a lifetime maximum of once per tooth/root:

- **Apexification/recalcification.**
- **Apicoectomy/periradicular** services (includes removal of granulation tissue at the apex of the tooth).
- **Retrograde filling.**
- **Root amputation/hemisection.**
- **Therapeutic pulpotomy** (excluding final restoration) limited to deciduous teeth only.

Oral Surgery Services

Treatment of certain dental conditions by operative or cutting procedures. Covered Services include extractions of non-impacted teeth, such as a single tooth or third molars (wisdom teeth), and other limited surgical procedures, as listed below. For surgical procedures related to the gums and to the bone that supports teeth, see *Periodontal Services*. For root canal procedures, see *Endodontic Services*.

- **Simple tooth extractions.**
- **Alveoloplasty.**
- **Vestibuloplasty.**
- **Surgical Biopsy.**
- **Excision of soft tissue lesions.**
- **Excision of intra-osseous lesions.**
- **Excision of bone tissue.**
- **Frenulectomy.**
- **Excision of hyperplastic tissue.**
- **Surgical incision and drainage.**

A biopsy report must be submitted with claims for the removal of tumors, cysts, or neoplasms. Surgical extraction of impacted wisdom teeth is a medical benefit. Claims should be filed with the Medical Plan Administrator. For more information, see your Medical Plan Document and Summary Plan Description.

Periodontal Services

Dental services that treat diseases of the tissues that surround and support the teeth (e.g., the gums and the supporting bone). Covered Services include maintenance of the gum tissues and bone that supports the teeth, as listed below.

Periodontal Surgical Services

Coverage for p**eriodontal surgical services i**ncludes routine postoperative care, limited to one surgical procedure per quadrant per Enrollee in any three years. Covered periodontal surgical services are:

- **Gingivectomy or gingivoplasty,** except when performed in conjunction with a crown build-up, post and core, or with a crown (the gingivectomy or gingivoplasty is considered part of that procedure and there will be no additional benefit).
- **Gingival flap procedure** (includes root planing).
- **Crown lengthening,** limited to once per tooth per lifetime.
- **Osseous surgery,** including flap entry with closure, limited to one quadrant of osseous surgery per Enrollee in any three years. (Surgical site is limited to the number of teeth with periodontal pockets of at least 5mm.)
- **Osseous grafts** (not in conjunction with extraction sites, ridge augmentation or in preparation for the placement of implants).
- **Soft tissue grafts** (includes donor site) (per site which is defined as a single graft covering two adjacent teeth).
- **Distal or proximal wedge procedure,** except when performed in conjunction with surgical procedures in the same anatomical area (only when a periodontal pocket of 5mm or more exists).

Other Periodontal Services

Covered adjunctive periodontal services are:

- **Full-mouth debridement** to enable comprehensive periodontal evaluation and diagnosis (removal of subgingival and/or supragingival plaque and calculus), limited to a lifetime maximum of once per Enrollee.
- **Periodontal scaling and root planing** if following osseous surgery or gingival flap procedure; however, six months must elapse between the time of osseous surgery or the gingival flap procedure, and the periodontal scaling and root planing. Periodontal scaling and root planing are limited to once per quadrant in any Calendar Year.
- **Periodontal maintenance procedures** only when following active periodontal therapy, limited to two cleanings per Calendar Year, whether routine or for periodontal maintenance.
- **Occlusal adjustment** (complete or limited) **and Occlusal guards** only if performed with osseous surgery or following osseous surgery received within the previous 12 months, limited to once in any three Calendar Years.

Missing Tooth Benefit

Removable prosthodontics (partials or dentures) or fixed prosthodontics (bridges) for the replacement of teeth (or tooth) lost prior to the Enrollee's Effective Date under this Plan Document and Summary Plan Description **are not** covered.

Mouth Rehabilitation

If you and your Dentist select a course of mouth rehabilitation, the Plan's obligation under this Plan Document and Summary Plan Description will be to cover only those services necessary to eliminate oral disease and replace covered missing teeth. The balance of the treatment, including costs of treatment and materials to increase vertical dimension or restore the occlusion, will remain the responsibility of the Enrollee.

Pretreatment Estimates and Treatment Plans

For services exceeding $300, a Treatment Plan from your Provider is recommended, but not required. Requests should be submitted on a standard claim form and are valid for 90 days. Telephone requests cannot be accepted, and verbal authorizations are not honored.

The Plan will send to the Enrollee and the provider of service a written estimate of Covered Services, benefit amounts payable, Deductible amount due, and maximum allowable amounts.

The Treatment Plan, radiographs, and diagnostic information are reviewed by actively practicing Dentists/Providers (when appropriate) who provide consultation services for the Plan. The Plan, with the consultant Dentist(s)/Provider(s), will determine the benefits available according to the terms and provisions of this Plan Document and Summary Plan Description.

Regardless of approval of a Treatment Plan, coverage under this Plan Document and Summary Plan Description must be maintained without interruption through the date that services are performed in order for benefits to be provided. Mail the Pretreatment Estimate request and Treatment Plan forms to the Anthem Dental address listed on your Identification Card.

Alternate Benefits

When a Provider performs or provides a treatment or service for which a satisfactory result could have been achieved through a different or less costly procedure or service, Anthem, on behalf of the Plan, reserves the right to determine alternate benefits based upon the less costly procedure. When the Plan provides alternate benefits for a service, the Enrollee is responsible for the balance of charges made by the Provider.

Cost Effective Alternatives

The Plan may use prudent business judgment by making limited exceptions to the terms of this Plan Document and Summary Plan Description. When the cost of equivalent services from different providers or suppliers varies significantly, the Plan may take these variations into consideration in determining benefits. These decisions are made only after establishing the cost effectiveness of a medically necessary service and with the understanding of the affected Enrollee. Any decisions do not, however, prevent the Plan from administering this Dental Plan in strict accordance with its terms in other situations.

General Exclusions

This section indicates items which are excluded and are not considered Covered Services**,** and to aid in identifying certain common items, which may be misconstrued as Covered Services. This list of Exclusions is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services. The Plan is the final authority for determining if services or supplies are covered.

The Plan does not provide benefits for services or supplies:

- Which the Plan determines are not specifically listed in the Plan Document and Summary Plan Description.
- Received from an individual or entity that is not a Provider, as defined in this Plan Document and Summary Plan Description.
- Which are Experimental/Investigational or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigational service or supply, as determined by Anthem, on behalf of the Plan.
- For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. This exclusion applies if you receive the benefits in whole or in part, or receive no Workers' Compensation benefits. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third-party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation. The payment of benefits under this Plan Document and Summary Plan Description will be coordinated with such governmental units to the extent required under existing state or Federal Laws.
- For illness or injury that occurs as a result of any act of war, declared or undeclared.
- For treatment of injuries sustained or illnesses resulting from participation in a riot or civil disturbance, or while committing or attempting to commit an assault or unlawful act, unless otherwise required by law. Services, supplies or other care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs.
- For court ordered care, unless authorized by the Plan or otherwise covered by the Plan Document and Summary Plan Description.
- For which you have no legal obligation to pay.
- Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
- Received from a member of your immediate family, including your spouse, child, brother, sister, or parent.
- For completion of claim forms or charges for medical/dental records or reports unless otherwise required by law.
- For missed or canceled appointments.
- Charges in excess of the Maximum Allowable Amount.
- Incurred prior to your Effective Date.
- Incurred after the termination date of this coverage except as specified elsewhere in this Plan Document and Summary Plan Description.
- Primarily for educational, vocational, or training purposes, except as otherwise specified herein.
- For any duplicate prosthetic device or other Appliance, or for a "spare" set of dentures or any other duplicate Appliance
- For athletic mouth guards.
- For bacteriological studies for determination of pathologic agents.
- For behavior management.
- For bleaching of discolored teeth.
- For canal preparation and fitting of prefabricated dowel and post.
- For caries susceptibility tests.
- For chemical treatments.
- For cosmetic services for beautification or aesthetic services to improve an individual's appearance by alteration of a physical characteristic, for psychiatric or psychological reasons, or to change family characteristics or conditions due to aging or incisal wear; for cosmetic replacement of serviceable amalgam restorations with silicate, plastic, or composite materials.

- For crown buildups on the same tooth as an amalgam or composite restoration that was done within the same Benefit Period.
- For restorations to restore occlusion, vertical dimension or incisal edges due to bruxism, attrition or harmful habits.
- For desensitizing medicaments and/or their application.
- For diagnostic photographs, casts, or models.
- For dietary instructions.
- For discing.
- Related to temporomandibular joint (TMJ) dysfunction, therapy or surgery, regardless of the reason(s) such services are necessary. Surgery for TMJ dysfunction is covered as a medical benefit. Please see your Medical Plan Document and Summary Plan Description.
- For enamel microabrasion.
- For fixed bridge when done in conjunction with a removable Appliance in the same arch.
- For grafts to improve aesthetics.
- For grafts to prepare for or that are associated with implants.
- For gold foil restorations.
- For guided tissue regeneration.
- For histopathological examinations.
- For house/hospital calls.
- For implants and services or supplies, such as bridges, grafts, dentures, or crowns that are provided in conjunction with implants.
- For local anesthetic when billed separately.
- For localized delivery of chemotherapeutic agents.
- For occlusal analysis.
- For oral hygiene instructions.
- For OSHA fees and/or infection control fees when billed separately.
- For osseous grafts if the following procedures have been performed on the affected tooth or site on the same date of service or within the previous 12 months:
  - Apicoectomy.
  - Extraction.
  - Hemisection.
  - Retrograde filling.
  - Root amputation.
  - Root canal therapy.
- For polishing of restorations.
- For post removal.
- For precision attachments for partials and/or dentures.
- For prefabricated resin crown or stainless steel crown with resin window.
- For prescription drugs.
- For pulp capping (direct or indirect).
- For pulp vitality tests.
- For pulpotomy on permanent teeth.
- For rebonding of a Maryland bridge.
- For recontouring.
- For removable unilateral partial denture.
- For replacement of a nonfunctional or nonrestorable tooth, e.g., a bridge to replace an extracted tooth root. Radiographic verification of a sound tooth at the time of initial membership eligibility may be required.
- For replacement of restorations due to mercury or other possible allergies.
- For resin crowns/onlays whether for single restorations, bridge retainers, or pontics.
- For restorations on the same tooth as a previously placed sealant if fewer than two years have elapsed since the time sealants were placed.
- For restoration overhang removal.
- For root canal therapy on deciduous teeth.
- For sealants on restored teeth (occlusal surface).

- For second professional opinions.
- For sedative fillings.
- For silicate restorations.
- For stress breakers.
- For therapeutic injections.
- For tissue conditioning procedures.
- For tobacco-use counseling.
- For upgrading of serviceable dentistry.
- For two similar services performed at the same time where one service is an integral part of a more extensive procedure.
- For prosthetic devices to replace teeth missing (congenitally or otherwise) lost or extracted before the Enrollee's Effective Date.
- For orthodontic services or supplies.
- For mucogingival surgery.
- For occlusal adjustments (complete or limited) except as specified otherwise in the Plan Document and Summary Plan Description.
- For provisional splinting.
- For services and supplies that do not meet the Plan's dental or benefit policy guidelines.
- For services or supplies not specifically listed in this Plan Document and Summary Plan Description.
- Surgical tooth extraction for impacted wisdom teeth is covered as a medical benefit, see your Medical Plan Document and Summary Plan Description.
- For denture adjustments.
- Any expenses for travel, whether or not recommended by a Dentist or Provider.
- Any expenses resulting from intentional self-inflicted injury or attempted intentional self-destruction while sane or insane.
- Any reconstructive dentistry or surgery unless such service is necessary for repair or alleviation of damage resulting from an accident which occurred while you are a participant in the Plan; because of infection or other disease which occurred while you are a participant in the Plan; or because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect provided the disease or anomaly occurred while you are a participant in the Plan.
- For prosthodontic services or supplies.

Administrative Information

How To File Claims

You are responsible for making sure a claim is filed in order to receive benefits. Many Providers will submit your claim for you. If you submit the claim, use a claim form.

How Benefits Are Paid

The Plan shares the cost of your dental expenses with you up to the amount of the Maximum Allowable Amount. For services subject to a Deductible, you must satisfy the Deductible before the Plan begins to pay its share of the balance.

The amount you pay may differ by the type of service you receive or by Dentist/Provider. Refer to the Summary of Dental Benefits to see what amount you are required to pay for each service. Claims for Covered Services need not be sent to the Plan in the same order that expenses were incurred.

Anthem, on behalf of the Plan, will deny that portion of any charge that exceeds the Maximum Allowable Amount.

Payment of Benefits

The Plan is not required to honor an assignment of benefits to Dentists or Providers. The Plan may honor an assignment of benefits to Providers at the Plan's sole discretion. If Anthem, on behalf of the Plan, pays you directly, you will be responsible for paying the provider of services for all charges. These payments fulfill the Plan's obligation to the Enrollee for these services.

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

Assignment

This Plan Document and Summary Plan Description is not assignable by the Plan without the written consent of the Plan. The coverage and any benefits under this Plan Document and Summary Plan Description are not assignable by any Member without the written consent of the Plan, except as described in this Plan Document and Summary Plan Description.

Notice of Claim

The Plan is not liable under the Plan Document and Summary Plan Description, unless the Plan receives written notice that Covered Services have been given to you. An expense is considered incurred on the date the service or supply was given.

Note: You have the right to obtain an itemized copy of your billed charges from the Provider who provided services.

Claim Forms

Claim forms will usually be available from most Dentists and Providers, Benefit Administrators/Contact Persons, www.ctsi.org and the Anthem Customer Service Department. If forms are not available, send a written request for claim forms to Anthem. If you do not receive the forms, written notice of services rendered may be submitted to the Plan without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name and address of Employee Participant.
- Identification number.
- Patient's name.
- Patient's age.
- Patient's relationship with the Employee Participant.
- Other dental coverage in effect.
- Date, type and place of service.
- Itemization of charges.
- Provider's name and address.

- Provider's tax ID number.
- Your signature and the Provider's signature.

Separate Claim Forms Required

A separate claim form is required for each Dentist or Provider for which you are requesting reimbursement. A separate claim form is also required for each Enrollee when charges for more than one family member are being submitted.

Out-of-State/Out-of-Area Claim Filing

Enrollees receiving services outside the state can file claims using the same procedures listed above in "Claim Forms."

Timely Filing Limits

All claims must be filed within 180 days after the date of service. Any claims filed after this time limit may be denied, unless the Plan is satisfied that there is a valid reason why the Enrollee could not submit his/her claim within this time limit.

If a claim must be returned to the Enrollee for additional information, the claim must be resubmitted to the Plan within 90 days of the date the claim was returned to the Enrollee.

If an Enrollee's coverage under this Plan Document and Summary Plan Description ends, claims for covered expenses incurred during the Enrollee's final Calendar Year must be filed within 60 days after the date of the coverage termination. Failure to file a claim within the 60 days will result in loss of benefits otherwise provided by this dental Plan Document and Summary Plan Description.

Time Benefits Payable

Anthem, on behalf of the Plan, will pay all benefits within 31 days after receiving all necessary information. The Plan may honor an assignment of benefits to Providers at its sole discretion. If Anthem pays you directly, you will be responsible for paying the provider of services for all charges. These payments fulfill the Plan's obligation to you for these services. If other parties have paid benefits under this Plan Document and Summary Plan Description, Anthem may reimburse those other parties and be fully discharged from that portion of the Plan's liability.

Enrollee's Cooperation

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

Anthem Information Practices Notice

The purpose of this information practices notice is to provide a notice to Enrollees regarding Anthem's standards for the collection, use, and disclosure of information gathered in connection with Anthem's business activities. The Plan may collect personal information about an Enrollee from persons or entities other than the Enrollee.

- The Plan may disclose Enrollee information to persons or entities outside of the Plan without Enrollee authorization in certain circumstances.
- An Enrollee has a right of access and correction with respect to all personal information collected by the Plan.
- The Plan takes reasonable precautions to protect Member information in its possession, including the use of restricted computer access.

Explanation of Benefits

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

- Total amounts charged for services/supplies received.
- The amount of the charges satisfied by your coverage.
- The amount for which you are responsible (if any).

Payment in Error

If Anthem, on behalf of the Plan, makes an erroneous benefit payment, Anthem may require the Enrollee the provider of service or the ineligible person to refund the amount paid in error. The Plan reserves the right to correct payments made in error by offsetting the amount paid in error against new claims. The Plan also reserves the right to take legal action to correct payments made in error.

General Provisions

General Provisions

Administration

The Plan, or anyone acting on the Plan's behalf, shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation and administration of this Plan Document and Summary Plan Description. This includes, without limitation, the power to construe the Contract and the Plan Document and Summary Plan Description, to determine all questions arising under this Plan Document and Summary Plan Description, and to make, establish and amend the rules and regulations and procedures with regard to the interpretation and administration of the provisions of this Plan Document and Summary Plan Description. However, these powers shall be exercised in such a manner that has a reasonable relationship to the provisions of the Contract and the Plan Document and Summary Plan Description. A specific requirement, limitation or Exclusion will override more general benefit language.

Amendment

The Plan reserves the right to amend or modify the Plan Document and Summary Plan Description.

Anthem Blue Cross and Blue Shield Note

County Health Pool, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan Document and Summary Plan Description constitutes a Contract solely between County Health Pool and Anthem, and that Anthem is the trade name of Rocky Mountain Hospital and Medical Services, Inc. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

Authority to Interpret Plan

The County Health Pool Board of Directors, or where Board of Directors' responsibility has been delegated to others, such delegates shall have complete authority to determine the standard of proof required in any case and to apply and interpret the Plan Document and Summary Plan Description. The decisions of the Board of Directors or its delegates shall be final and binding.

Catastrophic Events

In case of fire, flood, war, civil disturbance, court order, strike or other cause beyond the Plan's control, Anthem, on behalf of the Plan, may be unable to process Enrollee claims on a timely basis. No legal action or lawsuit may be taken against the Plan or Anthem due to a delay caused by any of these events.

Cessation of Operations

In the event of the cessation of operations or dissolution of the Plan, this Plan Document and Summary Plan Description may be terminated immediately by the Plan.

Changes to the Plan Document and Summary Plan Description

For modifications due to applicable Federal Law or regulation, Anthem may amend this Plan Document and Summary Plan Description when authorized by a Plan representative. The Plan will give the Enrollee access to any amendments following the effective date of the amendment.

No agent or employee of Anthem may change this Plan Document and Summary Plan Description. Such changes can be made only through an endorsement authorized and signed by County Health Pool and an officer of Anthem.

Clerical Error

Clerical error of the Plan, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

Contracting Entity

The Employee Participant hereby expressly acknowledges that the Employee Participant understands that the Plan Document and Summary Plan Description constitutes a Contract solely between the Plan and Anthem, an independent corporation operating under a license from the Blue Cross and Blue Shield Association, which is an association of independent Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield Association permits Anthem to use the Blue Cross and Blue Shield Service Mark, and in doing so, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association. The Employee Participant further acknowledges and agrees that the Employee Participant has not entered into the contract based on representations by any person other than an Anthem representative, and that no person, entity or organization other than Anthem will be held accountable or liable to the subscriber for any of Anthem's obligations created under the Plan Document and Summary Plan Description. This paragraph does not create any additional obligations whatsoever on Anthem's part other than those obligations created under other provisions of the Plan Document and Summary Plan Description.

Delivery of Documents

Anthem, on behalf of the Plan, will provide an Identification Card for each Enrollee. The Plan Document and Summary Plan Description is available at www.ctsi.org or by calling your CHP Benefits Administrator.
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Disagreement with Recommended Treatment

Each Enrollee enrolls with the understanding that the Dentist or Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper dental care. Dentists and Providers shall use their best efforts to render all medically necessary and appropriate dental care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper dental practice.

If you refuse to follow a recommended treatment or procedure, and the Dentist or Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Dentist or Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Disclosure and Release of Health Information

Ordinarily, Anthem, on behalf of the Plan, cannot release an Enrollee's health information without the Enrollee's written consent. That information is strictly confidential. Anthem may, however, release an Enrollee's health information without notice or consent when:

- Requested in connection with utilization summaries or review provided to a third-party, such as a Member, if that third-party funds all or a part of the cost of the Enrollee's claims.
- Peer and utilization review boards and Anthem's medical and/or dental consultants need such information for review in connection with services an Enrollee receives that may be covered under this Plan Document and Summary Plan Description.
- Anthem receives a judicial or administrative subpoena for such information.
- The information is required for Workers' Compensation proceedings, auto insurance cases, third-party liability (Subrogation) proceedings, coordination of benefits or Medicaid.

Anthem, on behalf of the Plan, cannot release information to an Enrollee that Anthem received from a Provider. If an Enrollee needs to review Dental or Provider records, the Enrollee must contact the Provider. Only an Enrollee's Dentist or Provider can release such information to the Enrollee.

The Enrollee must provide the Plan with whatever information is necessary to determine benefits on the Enrollee's claims and to carry out the provisions of this Plan Document and Summary Plan Description. Anthem, on behalf of the Plan, may obtain information from any insurance company, organization or person when such information is necessary to carry out the provisions of this Plan Document and Summary Plan Description. Such information may be exchanged without consent of or notice to the Enrollee.

The Enrollee agrees to cooperate at all times (including while the Enrollee is hospitalized) by allowing Anthem, on behalf of the Plan, access to the Enrollee's health records to investigate claims and verify information provided in the Enrollee's Enrollment Application/Change Form and/or Health Statement. If the Enrollee does not cooperate with the Plan, the Enrollee forfeits the right to benefit payments on claims subject to investigation and acknowledges the Plan's right to cancel the Enrollee's benefits.

To help the Plan determine which services and supplies qualify for benefits, the Enrollee authorizes all providers of health care services or supplies to provide the Plan with any medically related information pertaining to the Enrollee's treatment.

The Enrollee waives all provisions of law which otherwise restrict or prohibit providers of health care services or supplies from disclosing or testifying to such information.

Entire Contract

This Plan Document and Summary Plan Description, the Contract, any Riders, Endorsements or Attachments, and the individual applications of the Employee Participant and Dependents, if any, constitute the entire Contract between Anthem and County Health Pool and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to Anthem by County Health Pool and any and all statements made to County Health Pool by Anthem are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Plan Document and Summary Plan Description, shall be used in defense to a claim under this Plan Document and Summary Plan Description.

Form or Content of Plan Document and Summary Plan Description

No agent or employee of Anthem is authorized to change the form or content of this Plan Document and Summary Plan Description. Such changes can be made only through an endorsement authorized and signed by County Health Pool and an officer of Anthem.

Fraudulent Insurance Act

It is unlawful to knowingly provide false, incomplete or misleading facts or information to the Benefit Administrator/Contact Person for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of benefits and civil damages.

Insurance fraud results in cost increases for health care benefits. Enrollees can help decrease these costs by doing the following:

- Be wary of offers to waive copayments. This practice is usually illegal.
- Be wary of mobile health testing labs. Ask what the insurance company will be charged for the tests.
- Always review the Explanation of Benefits received from Anthem. If there are any discrepancies, call the Customer Service Department.
- Be very cautious about giving the Enrollee's health insurance benefits information over the phone.

If fraud is suspected, Enrollees should contact the Customer Service Department.

Anthem, on behalf of the Plan, reserves the right to recoup any benefit payments paid on behalf of an Enrollee if the Enrollee has committed fraud or material misrepresentation in applying for benefits in or receiving or filing for benefits.

Identification Card

When you receive care from a Dentist or Provider, you must show your Identification Card. Possession of an Identification Card confers no right to services or other benefits under this Plan Document and Summary Plan Description. To be entitled to such services or benefits you must be an Enrollee on whose behalf all applicable contributions under this Plan Document and Summary Plan Description have been paid. If you receive services or other benefits to which you are not then entitled under the provisions of this Plan Document and Summary Plan Description you will be responsible for the actual cost of such services or benefits.

Independent Contractors

Anthem has an independent contractor relationship with County Health Pool. County Health Pool is not Anthem's agent or employee, and Anthem's employees are not employees or agents of the County Health Pool.

Anthem may subcontract particular services to organizations or entities that have specialized expertise in certain areas. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims payment or Customer Service duties on Anthem's behalf.

Modifications

By this Plan Document and Summary Plan Description, the Plan makes coverage available to Employee Participants. However, this Plan Document and Summary Plan Description shall be subject to amendment, modification, and termination in accordance with any of its provisions, without the consent or concurrence of any Enrollee. By electing dental coverage under the Plan or accepting the Plan's benefits, all Enrollees legally capable of contracting and the legal representatives of all Enrollees incapable of contracting agree to all terms, conditions, and provisions hereof.

Nondiscrimination

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

Not Liable for Provider Acts or Omissions

Neither Anthem nor the Plan is responsible for the actual care you receive from any person. This Plan Document and Summary Plan Description does not give anyone any claim, right, or cause of action against the Plan or Anthem based on what a Provider of dental care, services or supplies, does or does not do.

Notice

Any notice given under this Plan Document and Summary Plan Description shall be in writing. The notices shall be sent to: The Plan at its principal place of business; to you at the Employee Participant's address as it appears on the records or in care of County Health Pool; and to Anthem at 555 Middle Creek Parkway, Colorado Springs, Colorado 80921.

No Withholding of Benefits for Necessary Care

Anthem does not compensate, reward or incent, financially or otherwise, Anthem's associates for inappropriate restrictions of care. Anthem does not promote or otherwise provide an incentive to employees or physician reviewers for withholding benefit approval for medically necessary services to which the Enrollee is entitled. Utilization review and benefit coverage decision making is based on appropriateness of care and service and the applicable terms of this Plan Document and Summary Plan Description.

Anthem does not design, calculate, award or permit financial or other incentives based on the frequency of: (1) denials of authorization for benefits; (2) reductions or limitations on hospital lengths of stay, medical services or charges; or (3) telephone calls or other contacts with health care providers or Enrollees.

Paragraph Headings

The headings used throughout this Plan Document and Summary Plan Description are for reference only and are not to be used by themselves for interpreting the provisions of the Plan Document and Summary Plan Description

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Plan Document and Summary Plan Description with which an Enrollee shall comply.

Relationship of Parties (Member-Enrollee-The Plan)

Neither the Member nor any Enrollee is the agent or representative of Anthem or the Plan.

County Health Plan is a fiduciary agent of the Enrollee. The Plan's notice to the Member will constitute effective notice to the Enrollee. It is the Member's duty to notify the Plan of eligibility data in a timely manner. The Plan is not responsible for payment of Covered Services of Enrollees if the Member fails to provide timely notification of Enrollee enrollments or terminations.

Research Fees

The Plan reserves the right to charge an administrative fee when extensive research is necessary to reconstruct information that has already been provided to the Enrollee in explanations of benefits, letters or other documents.

Right of Recovery

Whenever payment has been made in error, the Plan will have the right to recover such payment from you or, if applicable, the Provider. The Plan reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

Sending Notices

All Employee Participant notices are considered sent to and received by the Employee Participant when deposited in the United States mail with postage prepaid and addressed to either:

- The Employee Participant at the latest address in Anthem's eligibility records.
- County Health Pool, if applicable.

Statements and Forms

Employee Participants shall complete and submit to the Plan applications, or other forms or statements the Plan may reasonably request. Employee Participants or applicants for enrollment represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Plan is true, correct, and complete. Employee Participants and applicants for enrollment understand that all rights to benefits under this Plan Document and Summary Plan Description are subject to the condition that all such information is true, correct and complete. Any material misrepresentation by an Enrollee may result in termination of coverage as provided in the Termination section.

The Plan's Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Plan Document and Summary Plan Description. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies that would otherwise be required for the care and treatment of an Enrollee.

Waiver

No agent or other person, except an authorized representative of the Plan, has authority to waive any conditions or restrictions of this Plan Document and Summary Plan Description, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payor, the benefits under this Plan Document and Summary Plan Description shall not duplicate any benefits to which Enrollees are entitled or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Enrollees shall be paid by or on behalf of the Enrollee to the Plan.

Automobile Insurance Provisions

Anthem, on behalf of the Plan, will coordinate the benefits of this Plan Document and Summary Plan Description with the benefits of a complying automobile insurance policy.

A complying automobile insurance policy is an insurance policy approved by the Colorado Division of Insurance that provides at least the minimum coverage required by law, and one which is subject to the Colorado Auto Accident Reparations Act or Colorado Revised Statutes §§ 10-4-601 through 10-4-633. Any state or Federal Law requiring similar benefits through legislation or regulation is also considered a complying policy.

Coordination of Benefits

Enrollee benefits under this Plan Document and Summary Plan Description may be coordinated with the coverages afforded by complying policy. After any primary coverages offered by the complying policy are exhausted, Anthem will pay benefits subject to the terms and conditions of this Plan Document and Summary Plan Description. If there is more than one complying policy that offers primary coverage, each will pay its maximum coverage before the Plan is liable for any further payments.

Enrollees must fully cooperate with the Plan to make sure that the complying policy has paid all required benefits. The Plan may require Enrollees to take a physical examination in disputed cases. If there is a complying policy in effect, and the Enrollee waives or fails to assert the Enrollee's rights to such benefits, this Plan will not pay those benefits that could be available under a complying policy.

The Plan may require proof that the complying policy has paid all primary benefits prior to making any payments to the Enrollee. Alternatively, the Plan may but is not be required to pay benefits under this Plan Document and Summary Plan Description and later coordinate with or seek reimbursement under the complying policy. In all cases, upon payment, the Plan is entitled to exercise its rights under this Plan Document and Summary Plan Description and under applicable law against any and all potentially responsible parties or insurers. In that event, Anthem may exercise the rights found in this section, under the heading *Third-Party Liability: Subrogation*.

What Happens If an Enrollee Does Not Have Another Policy

The Plan will not pay benefits for injuries received by the Enrollee and/or the Enrollee's Dependents while the Enrollee is riding in or operating a motor vehicle that the Enrollee owns if the vehicle is not covered by an automobile complying policy as required by law.

The Plan will also pay benefits under the terms of the Plan Document and Summary Plan Description for injuries sustained by an Enrollee who is a non-owner-operator, passenger or pedestrian involved in a motor vehicle accident if that Enrollee's injuries are not covered by a complying policy. In that event, the Plan may exercise the rights found in this section, under the heading *Third-Party Liability: Subrogation/Reimbursement*.

Third-Party Liability: Subrogation/Reimbursement

When the Plan pays for your care and you have the right to recover those expenses from the person or organization causing your injury, you agree that the Plan has the right of subrogation to recover the total amount of benefits the Plan has paid. The Plan will have first priority in the payment. The Plan is subrogated to any right you may have to recover from another, his/her insurer, or under any "Uninsured Motorist," "Underinsured Motorist," "Medical/Dental Payments" or other similar coverage provisions. You also agree the Plan can exercise the Plan's right to direct recovery against you. You must hold in trust for the proceeds of any recovery, to be paid to the Plan immediately upon the recovery coming into your hands. You must reimburse the Plan, in first priority, to the extent of payments made.

The subrogation right and right of reimbursement apply to amounts recovered through a lawsuit or a settlement with any third-party or insurer, regardless of how you or your representative characterize the recovery.

You have the legal obligation to help recover the amounts paid, and you must do nothing that would prejudice the Plan's subrogation and/or reimbursement rights. You must provide the Plan any information requested by the Plan within five days of the request. You must notify the Plan if you file a personal injury claim, consult an attorney, or bring action against a third-party, and must send the Plan copies of any police report or other papers received in connection with the accident or incident resulting in personal injury to you and execute necessary documents to assist the Plan. You may not settle or compromise any claim unless the Plan is notified in writing at least thirty days before such settlement or compromise and the Plan agrees to it in writing. The Plan may suspend the payment of claims under this Plan Document and Summary Plan Description in the event you fail to cooperate with the Plan's efforts.

Workers' Compensation

The benefits under this Plan Document and Summary Plan Description are not designed to duplicate any benefit including work-related injuries, illnesses, or conditions for which Enrollees are eligible under the Workers' Compensation Law. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Workers' Compensation.

Complaints, Appeals and Grievance Procedure

This section explains what to do if an Enrollee disagrees with a claim denial in whole or in part, a benefit exception request denial or has a quality of care concern. This section includes instructions on initiating a complaint, filing an appeal or filing a grievance with the Plan.

Complaints

If an Enrollee has a complaint about any aspect of the Plan's service or claims processing, the Enrollee should contact the Customer Service Department by telephone or in writing. A Customer Service associate will work to clear up any confusion and resolve the Enrollee's concerns. An Enrollee may submit a written complaint to the address listed below. If the Enrollee is not satisfied with the resolution of their concern(s) by the Plan's Customer Service associate, the Enrollee may file an appeal as explained under the heading *Appeals* in this section:

Anthem
Customer Service Department
P.O. Box 17549
Denver, CO 80217-7549

If an Enrollee wants to request a benefit exception, the Enrollee should contact the Customer Service Department by telephone or in writing. The Customer Service associate will submit the request, obtain a decision and communicate the decision. If the Enrollee is not satisfied with the resolution of the request, the Enrollee may file an appeal as explained under the *Appeals* heading in this section.

A Provider may request a utilization exception on behalf of the patient by contacting the Anthem pre-authorization Department. If the Provider is not satisfied with the resolution of the request, the Provider may file a Utilization Review Appeal as explained under the *Appeals* heading. The Provider should contact the pre-authorization Department by telephone or in writing.

Appeals

The Enrollee's written appeal must be received by Anthem, on behalf of the Plan, within 60 days of the adverse benefit determination. Anthem will assign a Customer Advocate to assist the Enrollee in the appeal process. Enrollees may send written appeals to the following address:

Anthem
Appeals Department - CAT 0430
700 Broadway
Denver, CO 80273-0001

Although an appeal may be filed with or without first submitting a request or complaint, the Plan encourages all Enrollees to submit a request or complaint through the Customer Service Department before filing an appeal. In the appeal, the Enrollee must state plainly the reason(s) why the claim, or requested service or supply, should not have been denied. The Enrollee should include any documents not originally submitted with the claim, or request for the service or supply, and any information that may have a bearing on the Plan's decision.

The Enrollee may access two levels of appeal for a claims reconsideration appeal or a benefit exception appeal. The Provider and/or Enrollee may access three levels of appeal on a utilization review appeal.

Level 1 Appeal for Adverse Claims or Benefit Determinations — This is an appeal in which Anthem, on behalf of the Plan, appoints persons not involved in the initial determination to review the denial of the claim, requested service or supply. A person that was previously involved with the denial may answer questions, but is not involved in decision making. The Enrollee will receive a response to the Enrollee's Level 1 Appeal from Anthem within 30 calendar days of receipt of the appeal request for pre-treatment determinations. The Enrollee will receive a response to the Enrollee's Level 1 Appeals from Anthem within 60 calendar days for post-treatment determinations.

You are allowed to review your Appeals upon your request.

Level 2 Appeal for Adverse Claims or Benefit Determination — This is an appeal of an adverse benefit determination that has not been resolved to the Enrollee's satisfaction under the Level 1 Appeal process. The Level 2 Appeal must be requested within 60 calendar days after the Enrollee receives Anthem's response to the Level 1 Appeal decision.

Enrollees, or their representative, must send Level 2 Appeals, in writing, to the following address:

County Health Pool Board of Directors
C/O Benefits Manager
9380 Station Street, Suite 275
Lone Tree, CO 80124

The Board of Directors will issue a copy of the written decision to the Enrollee and/or the Enrollee's representative, or to the Provider who submits a Level 2 Appeal on the Enrollee's behalf, if any, within 60 workdays of the Board of Directors receipt of the Level 2 Appeal request.

Level 1 Appeal for Utilization Review Determinations — An example of a utilization review determination is situation where a provider requests the use of a general anesthetic and Anthem, on behalf of the Plan, denies the request for the general anesthesia. This is an appeal in which Anthem, on behalf of the Plan, appoints persons not involved in the initial determination to review the initial adverse determination. A person that was previously involved with the denial may answer questions, but is not involved in decision making. The persons appointed to review a Level 1 Appeal involving utilization review shall consult with appropriate clinical persons in the same specialty as would typically manage the case being reviewed. For utilization review issues, the Enrollee will receive a response from Anthem to the Enrollee's Level 1 Appeal within 20 workdays of receipt of the appeal request or within 30 calendar days if there is a holiday within the timeframe.

Enrollees may send Level 1 written Appeals to the following address:

Anthem
Appeals Department - CAT 0430
700 Broadway
Denver, CO 80273-0001

You are allowed to review your Appeals upon your request.

Level 2 Appeal for Utilization Review Determinations — This is an appeal of an adverse utilization review determination that has not been resolved to the Enrollee's satisfaction under the Level 1 Appeal process. The Level 2 Appeal must be requested within 60 calendar days after the Enrollee receives the Plan's adverse determination from the Level 1 Appeal. The Enrollee may appear in person or by telephone to present testimony, introduce documentation that the Enrollee believes supports their appeal, and/or provide documentation requested by Anthem, on behalf of the Plan, at a hearing concerning the appeal.

The panel of reviewers shall include a minimum of three people and may be composed of Anthem associates who have appropriate professional expertise. A majority of the panel shall be comprised of persons who were not previously involved in the dispute; however, a person who was previously involved with the dispute may be a member of the panel or appear before the panel to present information or answer questions. In the case of utilization review appeals, the majority of the persons reviewing the appeal shall be health care professionals who have appropriate expertise. Such reviewing health care professionals shall meet the following criteria:

- Has not been involved in the care previously.
- Is not a member of the Board of Directors of Anthem.
- Has not been involved in the review process for the covered person previously.
- Does not have a direct financial interest in the case or in the outcome of the review.

Anthem will issue a copy of the written decision, if any, to the Enrollee or to the Provider who submitted an appeal on the Enrollee's behalf, within 50 workdays of Anthem's receipt of the Level 2 Appeal request.

Send Level 2 written Appeals to the following address:

Anthem

Appeals Department – CAT 0430
700 Broadway
Denver, CO 80273-0001

Level 3 Appeal for Utilization Review Determinations — This is an appeal of an adverse utilization review determination that has not been resolved to the Enrollee's satisfaction under the Level 2 Appeal process. The Level 3 Appeal must be requested within 30 calendar days after the Enrollee receives the adverse determination of the Level 2 Appeal from Anthem, on behalf of the Plan.

Enrollees, or their representative, must send Level 3 Appeals, **in writing**, to the following address:

County Health Pool Board of Directors
C/O Benefits Manager
9380 Station Street, Suite 275
Lone Tree, CO 80124

The Board of Directors will issue a copy of the written decision, if any, to the Enrollee, to the Enrollee's representative, or to the Provider who submits a Level 3 Appeal on the Enrollee's behalf within 60 workdays of the Board of Directors receipt of the Level 3 Appeal request.

You are allowed to review your Appeals file upon your request.

Expedited Appeals (offered by Anthem only) — An Enrollee or Enrollee's representative has the right to request an expedited appeal of a utilization review determination when the time frames for a standard review would: seriously jeopardize the life or health of the covered person; jeopardize the covered person's ability to regain maximum function; or for persons with a disability, create an imminent and substantial limitation on their existing ability to live independently. Typically the decision will be made within 72 hours. Expedited Appeals will be evaluated by an appropriate clinical peer or peers who were not involved in the initial denial. Anthem, on behalf of the Plan, will not provide an expedited review for retrospective denials. **The Expedited Appeals process is not available for appeals sent to the County Health Pool Board of Directors for final review.**

Grievances

A grievance is a quality of care complaint. An Enrollee may send a written grievance to the following address:

Anthem
Quality Management Department
700 Broadway MC0532
Denver, CO 80273

Receipt of the Enrollee's grievance will be acknowledged by Anthem's Quality Management Department and the grievance will be investigated by Anthem's Quality Management Department. Anthem treats each grievance investigation in a strictly confidential manner. Enrollees will not be advised as to the outcome of the grievance investigation.

Legal Action

Before an Enrollee takes legal action on a claim decision, the Enrollee must first follow the process outlined under the heading A*ppeals* in this section and the Enrollee must meet all the requirements of this Plan Document and Summary Plan Description.

No action at law or in equity may be commenced later than one year after the time the Enrollee received the service in question. Performance of this Plan Document and Summary Plan Description shall take place in the City and County of Denver, Colorado. Any action arising at law or in equity under this Plan shall be brought in the courts of the City and County of Denver.

Limitation of Actions

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced no earlier than 60 days after the Plan receives the claim or other requests for benefits and within one year of the Plan's final decision on the claim or any other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request of the final decision date. You must exhaust the Plan's internal Appeals procedure before filing a lawsuit or other legal action of any kind against the Plan.

Glossary

This section defines words and terms used throughout the Plan Document and Summary Plan Description to help Enrollees understand the content. Enrollees should refer to this section to find out exactly how, for the purposes of this Plan document and Summary Plan Description, a word or term is used.

Accidental Injuries – Unintentional injuries which result in trauma, and are different from illness-related conditions.

Administrative Services Agreement – The agreement between the Plan and Anthem Blue Cross and Blue Shield stating all of the terms and provisions applicable to group benefits. The final interpretation of any specific provision contained in this Plan Document and Summary Plan Description is governed by the Administrative Services Agreement.

Alternate Benefits – Benefits for treatment or services that can be achieved through a different or less costly procedure or service with satisfactory results.

Anesthesia – The loss of normal sensation or feeling. There are two different types of anesthesia:

- General anesthesia, also know as total body anesthesia, causes the patient to become unconscious or "put to sleep" for a period of time.
- Local anesthesia causes loss of feeling or numbness in a specified area usually injected with a local anesthetic drug such as Lidocaine.

Annual Maximum – The maximum dollar amount the Plan will pay for Covered Services for each Enrollee during a Calendar Year, according to the terms of this Plan Document and Summary Plan Description and the coverage outlined on the Enrollee's Summary of Dental Benefits. The amounts applied to the Annual Maximum are based on the Maximum Allowable Amount for all Covered Services for which benefits were received. The annual benefit limit does not include the Enrollee's Deductible amount. Refer to the Benefit Summary for any Annual Maximum or Lifetime Maximum amounts.

Anthem Blue Cross and Blue Shield – Rocky Mountain Hospital and Medical Service, Inc., a Colorado insurance company doing business as Anthem Blue Cross and Blue Shield. Also referred to as "Anthem".

Appeal – A process for reconsideration of the Plan's decision regarding an Enrollee's claim, benefit exception, or utilization review request.

Appliance – A device used to provide a function or a therapeutic effect (example: a denture).

Assignment – A decision by the Enrollee to make benefits which ordinarily would be payable to such Enrollee payable directly to the Provider.

Authorization – Approval of benefits for a covered procedure or service.

Benefit Administrator/Contact Person – Person at the Member location responsible for managing benefits and enrollment, and coordinating benefit activities.

Benefit Period – The number of days or units of service, such as two examinations per Enrollee's Calendar Year, which the Plan will provide benefits for during a specified length of time.

Benefit Summary – The document, found in the front of the Plan Document and Summary Plan Description, which identifies the type of benefits, copayment, deductible and coinsurance information.

Billed Charges – A Provider's regular charges for services and supplies, as offered to the public generally and without any adjustment for any applicable PPO, Participating Provider, or other discounts.

Birthday Rule – The guideline that determines which of the two parents' insurance coverage is primary for coverage of the dependent child(ren). Generally, under the birthday rule, the parent whose birthday comes first during the year is considered to have the primary insurance coverage for the child(ren). Any balance may be submitted to the other parents' insurance carrier for additional consideration.

Board of Directors – the Board of Directors of County Health Pool.

Bylaws – Refers to the "County Health Pool Bylaws and Intergovernmental Agreement."

Calendar Year – That period of time beginning on the first day of January and ending on the last day of December in the same year.

Calendar Year Maximum – The maximum benefit an Enrollee may receive per calendar year.

CHP – Refers to the County Health Pool.

Cleft Palate – A birth deformity in which the palate (the roof of the mouth) fails to close.

Cleft Lip – A birth deformity in which the lip fails to close.

COBRA – An acronym for the Consolidated Omnibus Budget Reconciliation Act of 1985. This Federal Law allows individuals, in certain cases, to continue their group health insurance coverage for a specified period after termination of their employment for other qualifying events.

Coinsurance – A provision under which the Employee Participant and the Plan share costs incurred after the deductible is met, according to a specific formula. The amount of coinsurance the Enrollee pays to a Provider is calculated after the determination of the Maximum Allowable Amount, but before the Plan subtracts any discount(s) the Plan may have negotiated with the Provider.

Common-Law Spouse – One who is married at common law as interpreted by the courts of the State of Colorado. The requirements of a relationship to gain recognition as a common law marriage are cohabitation and general reputation as married. Both factors must be present. Mere cohabitation is not sufficient. To establish the presumption of marriage by cohabitation and repute there must be clear, consistent, convincing and positive evidence.

Complaint – An expression of dissatisfaction with the Plan's services or the practices of a Provider, whether dental or non-dental in nature. Contract -The contract between County Health Pool and Anthem Blue Cross and Blue Shield. It includes this Plan Document and Summary Plan Description, your Summary of Dental Benefits, the application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

Contract – The contract between County Health Pool and Anthem Blue Cross and Blue Shield. It includes this Plan Document and Summary Plan Description, your Summary of Dental Benefits, the application, any supplemental application or change form, your Identification Card, any Administrative Services Agreement, and any endorsements or riders.

Contract Administrator – Anthem Blue Cross and Blue Shield

Contribution or Costs – Monthly charges that the Enrollee and/or Member must pay to establish, administer and maintain benefits.

Coordination of Benefits – Also known as COB, a stipulation in most insurance policies that helps prevent duplicate payments for services covered by more than one policy or program of insurance. For example, an Enrollee may be covered by the Enrollee's own policy, as well as a spouse's policy. Eligible expenses are covered first by a person's own policy. Any balance is submitted to the spouse's carriers for additional consideration.

Cosmetic Services – Beatification procedures or services of a physical characteristic to improve an individual's appearance.

Cost Sharing – The general term for out-of-pocket expenses, e.g., copayments and deductibles, paid by an Enrollee.

Covered Services – Services and supplies or treatment as described in the Plan Document and Summary Plan Description. To be considered Covered Services, services must be:

- Within the scope of the license of the Dentist or Provider performing the service.
- Rendered while coverage under this Plan Document and Summary Plan Description is in force.
- Within the Maximum Allowable Amount.
- Authorized in advance by the Plan if this Plan Document and Summary Plan Description requires such pre-authorization.
- Not specifically excluded or limited by the Plan Document and Summary Plan Description.

- Not Experimental or Investigational or otherwise excluded or limited by the Plan Document and Summary Plan Description.
- Dental/medical necessity or otherwise specifically included as a benefit under this Plan Document and Summary Plan Description.
- Covered Services are subject to the Maximum Allowable Amount which is the maximum amount payable for Covered Services an Enroll receives, up to but not to exceed charges actually billed. If a service is not covered or if the Enroll has exceeded their benefits for Covered Services, the Provider is not limited by the Maximum Allowable Amount and they can charge up to the billed amount.

Creditable Coverage – A qualified prior coverage that an Employee Participant and/or Dependent had within 62 days prior to the Effective Date of the Plan's benefits. Prior creditable coverage includes Medicare or Medicaid coverage, a group insurance coverage, an individual benefit coverage, state high risk pool coverage, any federal or state benefit coverage or any other benefit coverage.

Customer Service Department – A department of representatives who are dedicated to answering and investigating Enrollee questions and issues related to the Plan.

Days – Calendar days.

Deductible – The dollar amount of Covered Services listed in the Summary of Dental Benefits for which you are responsible before the Plan starts to pay for Covered Services each Calendar Year. . Some Covered Services have a maximum benefit of visits, or dollar amounts allowed in a Benefit Period. When the Deductible is applied to a Covered Service which has a maximum benefit, the maximum benefit will be reduced by the amount applied toward the Deductible, whether or not the service is paid by this Plan Document and Summary Plan Description.

Dental/Medical Necessity — An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that Anthem, on behalf of the Plan, solely determines to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury.
- Obtained from a physician, dentist and/or licensed, certified or registered Provider.
- Provided in accordance with applicable medical, dental and/or professional standards.
- Known to be effective, as proven by scientific evidence, in materially improving health and/or dental outcomes.
- The most appropriate supply, setting or level of service that can safely be provided to the Enrollee and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained as an outpatient).
- Cost-effective compared to alternative interventions, including no intervention ("cost effective" does not mean lowest cost).
- Not Experimental/Investigational.
- Not primarily for the convenience of the Enrollee, the Enrollee's family or the Provider.
- Not otherwise subject to an exclusion under this Plan Document and Summary Plan Description.

The fact that a Dentist or Provider may prescribe, order, recommend or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies medically necessary or a Covered Service. Anthem, on behalf of the Plan, bases its decisions about dental and medical necessity on dental and medical policy developed by Anthem. Anthem may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of dental care services and technology.

Dental Service – A professional dental service that is included in the list of dental services in the COVERED SERVICES section and is rendered by a dentist in the necessary treatment of accidental injury, dental disease or defect. Dental Service also means the scaling and cleaning of teeth by a licensed dental hygienist or dental assistant if performed under the supervision and direction of a dentist and if a charge is made for such service by the dentist. Laboratory services for preparation of dental restoration and dental prosthetic devices are also included if the dentist includes the cost of such services or devices in his charges.

Dependent – A person of the Employee Participant's family who is eligible for coverage under the Plan Document and Summary Plan Description as described in the Eligibility section.

Disabled/Handicapped Dependent – Please refer to the *Employee Participant's Disable Dependents* heading in the ELIGIBILITY section for detailed disabled dependent requirements.

Effective Date – The date when an Enrollee's coverage begins under this Plan Document and Summary Plan Description. No benefits are provided for services and supplies received before your Effective Date or after your termination date.

Eligibility – A status necessary in order to elect or apply for coverage under the Plan.

Eligible Expenses – The Maximum Benefit Allowance made for medical services and supplies that most Physicians would consider to be medically necessary for treatment of a particular injury or illness.

Eligible Person – A person who satisfies the Member's eligibility requirements and is entitled to apply to be an Employee Participant or is an eligible Dependent of the Employee Participant. See the ELIGIBILITY section for more information.

Emergency – The sudden, and at the time, unexpected onset of a health condition that requires immediate attention where failure to provide attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

Employee – A person employed by a Member.

Employee Participant – The Employee in whose name the eligibility with the Plan is established.

Enrollee – An Employee Participant or Dependent who has satisfied the Member's eligibility conditions, applied for coverage, been approved by County Health Pool and for whom Contributions have been made. Enrollees are sometimes called "you" and "your."

Enrollment Date – The first day of coverage or, if there is a waiting period, the first day of the waiting period.

Entrant – Applicant to this Plan.

Exclusions - Procedures, conditions, injuries, services and expenses incurred for treatment which will not be paid. See the "General Exclusions" section in this Plan Document and Summary Plan Description.

Experimental/Investigational - (a) Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation or treatment of a disease, injury, illness or other health condition which Anthem, on behalf of the Plan, determines in its sole discretion to be experimental or investigational.

Anthem will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply to be experimental or investigational if it determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought.

The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA) or any other state or federal regulatory agency, and such final approval has not been granted.
- Has been determined by the FDA to be contraindicated for the specific use.
- Is provided as part of a clinical research protocol or clinical trial, or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic,

product, equipment, procedure, treatment, service or supply; or is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function.

- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as experimental/investigational, or otherwise indicate that the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation.

(b) Any service not deemed experimental or investigational based on the criteria in subsection (a) may still be deemed to be experimental or investigational by Anthem. In determining whether a service is experimental or investigational, Anthem will consider the information described in subsection (c) and assess all of the following:

- Whether the scientific evidence is conclusory concerning the effect of the service on health outcomes.
- Whether the evidence demonstrates that the service improves the net health outcomes of the total population for whom the service might be proposed as any established alternatives.
- Whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

(c) The information Anthem considers or evaluates to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is experimental or investigational under subsections (a) and (b) may include one or more items from the following list, which is not all-inclusive:

- Randomized, controlled, clinical trials published in authoritative, peer-reviewed United States medical or scientific journal
- Evaluations of national medical associations, consensus panels and other technology evaluation bodies
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply
- Documents of an IRB or other similar body performing substantially the same function
- Consent documentation(s) used by the treating physicians, other medical professionals or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply
- The written protocol(s) used by the treating physicians, other medical professionals or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply
- Medical and/or dental records
- The opinions of consulting Providers and other experts in the field

(d) Anthem has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is experimental or investigational.

Explanation of Benefits – Also known as EOB, a printed form sent by Anthem, on behalf of the Plan, to an Enrollee after a claim has been filed and adjudicated. The EOB includes such information as the date of service, name of Provider, amount covered and patient balance. An explanation of Medicare benefits, or EOMB, is similar, except it is sent following submission of a Medicare claims.

Family Coverage – Coverage for the Employee Participant and eligible Dependents.

Family Eligibility – An eligibility that covers two or more persons (the Employee Participant and one or more Dependents).

Full-Time Employee – An Employee who meets the requirements of full-time employee status as stated in the ELIGIBILITY section.

General Policies - The guidelines adopted by the Board of Directors concerning the governance and operation of County Health Pool.

Grievance – A written complaint about the quality of care, denial of a benefit or service received from a Provider.

Hospital - A health institution offering facilities, beds and continuous services 24 hours a day and meets all licensing and certification requirements of local and state regulatory agencies.

Identification Card – A card that identifies membership by number, Effective Date of Coverage and may contain information about your coverage. It is important to carry this card with you.

Illness – Non-occupational illness or disease, including pregnancy, which results in a loss covered by the Plan.

Incurred Charge or Expense – The charge for a service or supply is considered incurred on the date furnished. Charges must also be defined as "eligible" if they are to be considered for payment under this Plan Document and Summary Plan Description.

Individual Eligibility – An Eligibility covering one person (the Employee Participant).

Injury – Non-occupational bodily damage resulting from an accident occurring while the individual is covered and causing a loss covered by the Plan.

Laboratory and Pathology Services – Testing procedures required for the diagnosis and treatment of a condition. Generally, these services involve the analysis of a specimen of tissue or other material that has been removed from the body.

Late Entrant – An Entrant who submits an enrollment application after the waiting period of the Qualifying Event period expires.

Licensed – In reference to Eligible Providers means that the institution or individual is licensed to provide services by the jurisdiction in which services are delivered.

Maximum Allowable Amount – The amount Anthem, on behalf of the Plan, determines is the maximum amount payable for Covered Services, not to exceed charges actually billed. Anthem's determination considers:

- Amounts charged by other Providers for the same or similar service.
- Any unusual dental and/or medical circumstances requiring additional time, skill or experience.
- Other factors Anthem determines are relevant, including but not limited to, a resource based relative value scale.

Member –- Refers to an entity, or a combination of entities that have collectively agreed to combine through Intergovernmental Agreement to select one entity as primary and all agree to the same plan/benefit package, which has joined County Health Pool through Intergovernmental Agreement or Member Affiliated Entity status and has adopted its Bylaws and General Policies**.**

Member Affiliated Entity – An entity accepted for plan participation by the County Health Pool Board of Directors over which the Member's governing body has at least one of the following controls:

- Approves 50% or more of the governing body of the entity.
- Approves the budget of the entity.
- Provides 50% or more of the funding of the entity.
- Hires, fires or directs the activities of those performing the activities of the entity.

Part-Time Employee – an Employee who meets the requirements of part-time employee status as stated in the ELIGIBILITY section.

Plan Administrator - County Health Pool serves as Plan Administrator. The Plan Administrator may contract with a qualified Contract Administrator.

Plan Document and Summary Plan Description – This document, which explains the benefits, limitations, exclusions, terms, and conditions of this dental benefit plan. In the event of any discrepancy, ambiguity or conflict between the terms of the Plan Document and Summary Plan Description and any other Plan document, the terms of the Plan Document and Summary Plan Description control.

Pre-Authorization – A process in which requests for services are reviewed prior to service for approval of benefits.

Pretreatment Estimate – A Pretreatment Estimate, which is recommended, but not required, identifies the Plan's estimated financial liability before treatment is started. This estimate may include some or all of the following information:

- Patient's eligibility.
- Covered Services.
- Benefit amounts payable.
- Deductible amounts, if applicable.
- Maximum benefit limitations.

Such estimates are subject to the terms of the Enrollee's coverage and are valid for 90 days from the date the estimate is completed.

Preventive Care – Comprehensive care that emphasizes prevention, early detection, and early treatment of conditions.

Prosthesis – An artificial body part.

Provider – A person or facility recognized by the Plan as a dental or health care Provider and that fits one or more of the following descriptions:

Professional Provider — A dentist or physician or other professional Provider who is licensed or otherwise authorized by the state or jurisdiction where services are provided to perform designated dental and/or health care services. For benefits to be payable, services of a Provider must be within the scope of the authority granted by the license and covered by this Plan Document and Summary Plan Description. Such services are subject to review by a dental and/or medical authority appointed by the Plan.

Facility Provider — There are two types of Facility Providers, inpatient and outpatient.

- Inpatient Facility Provider — a hospital, alcoholism treatment center, residential treatment center, hospice facility, skilled nursing facility or other facility which the Plan recognizes as a dental or health care Provider.
- Outpatient Facility Provider — a facility recognized by the Plan and licensed or certified to perform designated health care services by the state or jurisdiction where services are provided. Services of such a Provider must be among those covered by this Plan Document and Summary Plan Description.

Qualified Beneficiary – Generally means an individual who, on the day before a Qualifying Event defined in this section, is covered by the Plan as an Employee Participant or an Employee Participant's Dependent.

- An Employee Participant can be a Qualified Beneficiary only in connection with a Qualifying Event set forth below, (termination of coverage due to termination of employment or reduction in hours).
- A newborn child, adopted child of a Qualified Beneficiary or a child placed for adoption with a Qualified Beneficiary who was not an Employee Participant will be entitled to the same continuation coverage period available to the Qualified Beneficiary, however, such child shall not become a Qualified Beneficiary. A newborn child, adopted child or child placed for adoption with a Qualified Beneficiary who was an Employee Participant shall become a Qualified Beneficiary in his/her own right and shall be entitled to benefits as a Qualified Beneficiary.
- A Qualified Beneficiary must notify the Member within thirty-one (31) days of the child's birth, adoption or placement for adoption in order to add the child to the continuation coverage.
- A person who becomes the spouse of a Qualified Beneficiary (regardless of whether the Qualified Beneficiary is the Employee Participant) after a Qualifying Event is not a Qualifying Beneficiary.
- An Employee Participant or an Employee Participant's Dependent, who does not elect COBRA coverage in connection with a Qualifying Event ceases to be a Qualified Beneficiary at the end of the election period.
- An individual who elects COBRA coverage ceases to be a Qualified Beneficiary once the Plan's obligation to provide COBRA coverage has ended.

Qualifying Event – Any of the following events:

- Termination of coverage due to the death of an Employee Participant.
- Termination of coverage due to the voluntary or involuntary termination of employment (other than by reason of gross misconduct) or reduction in hours of an Employee Participant.
- Termination of coverage due to an Employee Participant's change in status, to a classification not covered by the Plan.
- The divorce or legal separation of an Employee Participant from his/her spouse.
- Termination of coverage due to an Employee Participant becoming enrolled in either Part A or Part B of Medicare coverage.
- A Dependent child ceasing to be a Dependent child as defined in ELIGIBILITY in this document.

Recovery –Money you receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical/Dental-Payments", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of the Plan.

Re-Enrollment – During this period, Enrollees may enroll themselves and their Dependents for benefits or change benefits, if this option is available.

Referral – Authorization for an Enrollee to visit another Provider.

Same Sex Domestic Partner- Two individuals, of the same sex, who live together in a long-term relationship of indefinite duration with an exclusive mutual commitment in which the Domestic Partners agree to be jointly responsible for each other's common welfare to share financial obligations.

Single Coverage – Coverage for the Employee Participant only.

Special Enrollment – An enrollment period offered when an Employee Participant and/or Dependents lose coverage under another plan.

Spouse – An Employee Participant's legal or common-law spouse.

Surgery – Any variety of technical procedures for treatment or diagnosis of anatomical disease or injury, including, but not limited to cutting, microsurgery (use of scopes), laser procedures, grafting, suturing, castings, treatment of fractures and dislocations, electrical, chemical or medical destruction of tissue, endoscopic examinations, anesthetic epidural procedures, and other invasive procedures. Covered surgical services also include usual and related anesthesia and pre- and post-operative care.

The Plan – County Health Pool Plan.

Treatment Plan – A detailed description, submitted by the Provider, outlining the proposed services and fees including any appropriate radiographs and diagnostic information. A new Treatment Plan should be filed if the patient's condition changes, or if the treatment is not completed within 90 days of the approval date.

Utilization Review – a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy of efficiency of, health care services, procedures or settings. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, care management, discharge planning and/or retrospective review. Utilization review also includes reviews to determine coverage. This is based on whether or not a procedure or treatment is considered experimental/investigational in a given circumstance (except if it is a specific Plan Document and Summary Plan Description exclusion), and review of an Enrollee's medical circumstances when necessary to determine if an exclusion applies in a given situation.

X-Ray and Radiology Services - services including the use of radiology, nuclear medicine and ultrasound equipment to obtain a visual image of internal body organs and structures, and the interpretation of these images.

PLAN INFORMATION

The "Plan Administrator" for the plan is the County Health Pool

9380 Station Street, Suite 275

Lone Tree, CO 80124

Telephone (303)861-0507

The **"Contract Administrator"** for the Plan is Anthem Blue Cross and Blue Shield

700 Broadway, Denver, CO 80273

Telephone or 1(866) 698-0087

The **Prescription Provider** for the plan is Anthem APM

700 Broadway Denver CO 80723

Telephone 1 (800) 698-0087

The **Dental Provider** for the Plan is Anthem Dental

PO BOX 1115, MINNEAPOLIS, MN 55440-1115

Telephone 1 (855)-769-1467