

BLUE EDGE DENTAL BENEFITS

Dental Program

**Carnegie Mellon University Student Plan
Group 10566604
Effective August 01, 2026**

This booklet relates to a Limited Policy - Read it Carefully

**Highmark Inc.
d/b/a Highmark Blue Cross Blue Shield
An independent licensee of the Blue Cross and Blue Shield Association**

BB-DENT-WG-NG-5



myhighmark.com

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with:

Civil Rights Coordinator
P.O. Box 22492
Pittsburgh, PA 15222
Phone: 1-866-286-8295 (TTY: 711), Fax: 412-544-2475
Email: CivilRightsCoordinator@highmarkhealth.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at hhs.gov/ocr/office/file/index.html

ATTENTION: If you speak English, free language translation and interpretation services are available to you. Appropriate auxiliary aids and services (such as large print, audio, and Braille) to provide information in accessible formats are also available free of charge. Call the number on the back of your ID card (TTY: 711) for help.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de traducción e interpretación de idiomas. También hay disponibles ayudas y servicios auxiliares adecuados (como letra grande, audio y Braille) para proporcionar información en formatos accesibles sin cargo. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711) si necesita ayuda.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Übersetzungs- und Dolmetscherdienste zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen (wie Großdruck, Audio und Blindenschrift) zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich. Wählen Sie hierfür bitte die Nummer auf der Rückseite Ihrer Ausweiskarte (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis tradiksyon ak entèpretasyon aladispozisyon w gratis nan lang ou pale a. Èd ak sèvis siplemantè apwopriye (tèlke gwo lèt, odyo, Braille) pou bay enfòmasyon nan fòm aksesib yo disponib gratis tou. Rele nimewo ki sou do Kat ID w lan (TTY: 711) pou jwenn èd.

ВНИМАНИЕ: Если Вы говорите на русском языке, Вам доступны бесплатные услуги перевода на другой язык. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах (например, крупным шрифтом, шрифтом Брайля или в виде аудиозаписи). Для получения помощи позвоните по номеру, указанному на обратной стороне вашей идентификационной карты (TTY: 711).

ATTENZIONE: se parla italiano, sono disponibili servizi gratuiti di traduzione e interpretariato. Sono inoltre disponibili gratuitamente adeguati supporti e servizi ausiliari (ad esempio caratteri grandi, audio e Braille) per fornire informazioni in formati accessibili. Per assistenza, chiami il numero riportato sul retro della Sua tessera di identificazione (TTY: 711).

ATTENTION : si vous parlez français, des services de traduction et d'interprétation gratuits sont à votre disposition. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés (affichage en gros caractères, audio et le braille) dans des formats accessibles. Veuillez appeler le numéro qui se trouve au verso de votre carte d'identification (TTY : 711) pour obtenir de l'aide.

ÀKÍYÈSÍ: Tí o bá nsọ èdè Yorùbá, àwọn isẹ ìtumọ ati ògbufọ èdè wà ní àrọwọtọ lófẹ́ẹ́ fún ọ. Àwọn isẹ ìtọ́jú ati ìrànlowọ tó yẹ (bíi titẹwé nla, gbigbo ohùn, ati iwé afójú) lati pèsè iwífúnni ni àwọn ọna irááyè si wà pẹlu lófẹ́ẹ́. Pe nọmba tó wà lẹhin kaádì idánimọ rẹ (TTY: 711) fún irànlowọ.

אכטונג: אויב איר רעדט אידיש, קענט איר באקומען שפראך איבערזעצונג און דאלמעטשונג סערוויסעס פריי פון אפצאל. געהעריגע הילפסמיטלען און סערוויסעס (אזוויי גרויסע דרוק, אודיא און ברעיל) צו צושטעלן אינפארמאציע אין צוגענגליכע פארמאטן זענען אויך דא צו באקומען פריי פון אפצאל. רופט דעם נומער אויף די אנדערע זייט פון אייער אידענטיטעט קארטל (TTY: 711) פאר הילף.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات الترجمة التحريرية والترجمة الفورية مجاناً. تتوفر أيضاً الوسائل والخدمات المساعدة المناسبة (مثل الطباعة الكبيرة، والوسائل الصوتية، وطريقة برايل) لتقديم المعلومات بتنسيقاتٍ يمكن الوصول إليها من دون أي تكلفة. اتصل على الرقم المدون على ظهر بطاقة هويتك (TTY: 711) للحصول على المساعدة.

注意：如果您说中文，我们将为您提供免费的语言翻译和口译服务。此外，我们还免费提供相应的辅助工具和服务（如大字、音频和盲文），以便您获取无障碍格式的信息。如需帮助，请拨打您的ID卡背面的号码（听障人士专用号码：711）。

ધ્યાન આપશો: જો તમે ગુજરાતી બોલતા હોવ, તો તમારા માટે નિ:શુલ્ક ભાષા અનુવાદ અને ઇન્ટરપ્રિટેશન સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનસામગ્રી અને સેવાઓ (જેમ કે મોટી પ્રિન્ટ, ઓડિયો અને બ્રેલ) પણ નિ:શુલ્ક ઉપલબ્ધ છે. મદદ માટે તમારા આઇડી કાર્ડની પાછળ આપેલા નંબર (TTY: 711) પર કોલ કરો.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ biên dịch và phiên dịch ngôn ngữ miễn phí dành cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp (như chữ in lớn, tệp âm thanh và chữ nổi) để cung cấp thông tin ở các định dạng dễ tiếp cận. Vui lòng gọi số điện thoại trên mặt sau của thẻ nhận dạng của quý vị (TTY: 711) để được trợ giúp.

ધ્યાન દિનુહોસ્: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंलाई नि:शुल्क भाषा अनुवाद र दोभासे सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक प्रविधि र सेवाहरू (जस्तै ठूलो प्रिन्ट, अडियो र ब्रेल) पनि नि:शुल्क उपलब्ध छन्। मददको लागि तपाईंको ID कार्डको पछाडिको नम्बरमा कल गर्नुहोस् (TTY: 711)।

कृपया ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए मुफ्त भाषा अनुवाद और व्याख्या संबंधी सेवाएं उपलब्ध हैं। एक्सेस करने योग्य फॉर्मेट में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक सामग्री और सेवाएं (जैसे बड़े प्रिंट, ऑडियो और ब्रेल) भी नि:शुल्क उपलब्ध हैं। सहायता के लिए अपने पहचान कार्ड के पीछे लिखे नंबर (TTY: 711) पर कॉल करें।

주의: 한국어를 사용하는 경우 무료 언어 번역 및 통역 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공받을 수 있는 적절한 보조 수단 및 서비스(예: 큰 활자, 오디오, 점자)도 무료로 이용할 수 있습니다. 도움이 필요하시면 ID 카드 뒷면에 있는 번호로 전화하십시오(TTY: 711).

Highmark Blue Cross Blue Shield is very pleased to provide this information about your dental care program. Read it carefully and keep it in a safe place with your other valuable documents. Review it to become familiar with your benefits and when you have a specific question regarding your coverage.

This booklet does not constitute a contract of benefits and provisions. The complete set of terms of coverage are set forth in the group contract issued by Highmark Blue Cross Blue Shield. Highmark Blue Cross Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association. Should the information in this booklet differ from the information contained in the group contract, the terms of the group contract shall govern. This booklet is merely a description of the principal features of your Blue Edge Dental program.

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Non-Assignment

Unless otherwise required by law, Highmark is authorized by the member to make payments directly to providers furnishing Covered Services provided under the program described in this benefit booklet; however, Highmark reserves the right to make these payments directly to the member. The right of a member to receive payment for a Covered Service described in this benefits booklet is not assignable, except to the extent required by law, nor may benefits described in this benefit booklet be transferred either before or after Covered Services are rendered. Any (direct or indirect) attempt to accomplish such an assignment shall be null and void. Nothing contained in this benefit booklet shall be construed to make Highmark, the group health plan or the group health plan sponsor liable to any assignee to whom a member may be liable for medical care, treatment, or services.

How Your Benefits Are Applied - Dental Program

Benefit Period

The specified period of time during which charges for covered services must be incurred in order to be eligible for payment by Highmark. A charge shall be considered incurred on the date you receive the service, product or supply for which the charge is made.

Your benefit period is 12 consecutive months beginning on 1.

Coinsurance

Those remaining percentages or dollar amounts of the maximum allowable charge for a covered service that are your responsibility after Highmark pays the percentages or dollar amounts shown on the Summary of Benefits for a covered service.

Deductible

A specified amount of expenses set forth in the Summary of Benefits for covered services that you must be pay before Highmark will pay any benefit.

Member Liability

In order to keep the program affordable for you, Highmark includes certain cost-sharing features. If the class or service grouping is not covered under the program, the Summary of Benefits will indicate either “not covered” or “Plan Pays -- 0%”. You will be responsible to pay your dentist the full charge for these uncovered services.

Classes or service groupings shown with “Plan Pays” percentages greater than 0% but less than 100% require you to pay a portion of the cost for the covered service. For example, if the program pays 80%, your share or coinsurance is 20% of the maximum allowable charge. You are also responsible to pay any deductibles, charges exceeding the program maximums or charges for covered services performed before satisfaction of any applicable waiting periods or which are not eligible for payment following the application of program benefit limitations. If you receive covered services from an out-of network provider, the plan will apply the percentages shown in the Summary of Benefits and you will be responsible for the difference, up to the provider’s charge.

Maximum

The greatest amount Highmark is obligated to pay for all covered services rendered during a specified period as shown in the Summary of Benefits.

Limitations

Certain services on the Summary of Benefits are subject to frequency or age limitations. See the section Covered Services for any limitations. Before reviewing the limitations, you must first check the Summary of Benefits to see which services are covered.

Payment For Network Covered Expenses

If you have services performed by a network dentist, Highmark will pay covered benefits directly to the network dentist. Both you and the dentist will be notified of benefits covered, the plan's payment and any amounts you owe for coinsurance, deductibles, charges exceeding annual maximums or charges for services not covered. Payment will be based on the maximum allowable charge (MAC) that the treating network dentist has contracted to accept. MAC charges may vary depending on the geographical area of the dental office and the contract between Highmark or its designated agent and the particular network dentist rendering the service. Network dentists agree by contract to accept MAC as payment in full for covered services rendered to you. You shall be held harmless if, after receiving services from a network dentist, such services are determined not to be dentally necessary.

Payment For Out-of-Network Covered Expenses

If you receive services from an out-of-network dentist, Highmark will send payment for covered benefits to you, unless the claim submitted by you indicates that payment should be sent directly to the dentist that performed the services. This is called assignment of benefits and is available for care delivered by out-of-network dentists outside of Pennsylvania. You will still be notified whether the services you received are covered, the plan payment and any amounts that you owe for coinsurance, deductibles, charges exceeding annual maximums, services not covered due to benefit frequency limitations or charges for services not covered by your program. Highmark's payment will be based on the maximum allowable charges (MAC) for the services. You will be responsible to pay the dentist any difference between the plan's payment and the out-of-network dentist's full charge for the services. Out-of-network dentists are not obligated to limit their fees to the plan's MAC. Dental emergency services performed by an out-of-network dentist will be reimbursed by the plan so that you are not liable for a greater out of pocket expense than if you were treated by a network dentist.

Description of Benefits

The general descriptions below explain the services on the Summary of Benefits. The descriptions are not all-inclusive – they include only the most common dental procedures in a class or service grouping. Specific dental procedures may be shifted among groupings or classes or may not be covered depending on your program.

Check the Summary of Benefits section to see which services are covered (“Plan Pays percentage greater than “0%”). Also, have your provider call Highmark to verify coverage of specific dental procedures or log on to www.myHighmark.com to check coverage.

Covered services are limited as detailed below. ***Limitations may differ by the state in which you receive services. Some limitations may be waived depending on your medical condition. Only American Dental Association procedure codes are covered.***

Also, be sure to review the section, What is Not Covered for exclusion information.

Exams (oral evaluations)

Oral examination and evaluation of the member by a provider. Examinations may be comprehensive and periodic, limited problem focused and consultations and detailed problem focused.

- Benefits for Oral Evaluations are limited to:
 - Comprehensive and periodic – of these services per . Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for or more years.
 - Limited problem focused and consultations – of these services per dentist per patient per .
 - Detailed problem focused – per dentist per patient per eligible diagnosis.

X-rays (full mouth, bitewing and occlusal)

Bitewings, periapical and full-mouth x-rays. Benefits are limited to:

- Full mouth x-rays – set every 0 years.
- Bitewing x-rays – sets per 0 under age and sets per 0 age and older.

Cleanings, Fluoride Treatments, Sealants for prevention

Benefits are limited to:

- Prophylaxis – per .
- Fluoride treatment – per for members under age 0.
- Sealants – per tooth every 0 between ages 6 and 0 on permanent first and second molars.

Palliative Treatment for relief of pain for dental emergencies.

Space Maintainers to prevent tooth movement.

- Space maintainers – per period for members under age 0 when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not, develop.

Other Benefit Limitations

- An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit you to the less costly treatment. However, if you and the dentist choose the more expensive treatment, you are responsible for the additional charges beyond those allowed under this ABP.

What Is Not Covered - Dental Program

Except as specifically provided in this program or as Highmark is mandated or required to cover based on state or federal law, regulation or other directive, no benefit will be provided for services or charges that are:

- started prior to your effective date or after the termination of coverage under the group program (e.g. multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures).
- for house or hospital calls for dental services and for hospitalization costs (e.g. facility-use fees).
- for prescription and non-prescription drugs, vitamins or dietary supplements.
- administration of nitrous oxide and/or IV sedation, unless specifically indicated on the Summary of Benefits.
- which are cosmetic in nature as determined by Highmark (e.g. bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).
- elective procedures (e.g. the prophylactic extraction of third molars).
- for congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment). This exclusion does not apply to the treatment of medically diagnosed congenital defects or birth abnormalities of a newborn dependent child or newly adopted children, regardless of age.
- for dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically covered under the program.
- diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the program. Examples of these jaw joint problems include, but are not limited to, temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.
- for treatment of fractures and dislocations of the jaw.
- for treatment of malignancies or neoplasms.
- services and/or appliances that alter the vertical dimension (e.g. full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.
- replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
- preventive restorations.
- periodontal splinting of teeth by any method.
- for duplicate dentures, prosthetic devices or any other duplicative device.
- for which in the absence of insurance, you would incur no charge.
- for plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
- for any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.
- for treatment and appliances for bruxism (e.g. night grinding of teeth).
- for any claims you submit or which are submitted on your behalf to Highmark in excess of 12 months after the date of service.
- incomplete treatment (e.g. patient does not return to complete treatment) and temporary services (e.g. temporary restorations).
- procedures that are part of a service but are reported as separate services; reported in a treatment sequence that is not appropriate; or misreported or that represent a procedure other than the one reported.
- specialized procedures and techniques (e.g. precision attachments, copings and intentional root canal treatment).
- those not dentally necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of Highmark will apply.
- not prescribed by or performed by or upon the direction of a provider.

- rendered by other than a provider.
- rendered by a provider who is a member of your immediate family.
- experimental/investigative in nature.
- to the extent benefits are provided to members of the armed forces while on active duty or to patients in veteran's administration facilities for service-connected illness or injury, unless you have a legal obligation to pay.
- for any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease, or similar type legislation. This exclusion applies whether or not the member files a claim for said benefits or compensation.
- for treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including any medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act.
- for telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
- for otherwise covered services ordered by a court or other tribunal as part of your or your dependent's sentence.
- for any tests, screenings, examinations or any other services required by: a) an employer or governmental body or agency in order to begin or to continue working or as a condition to performing the functions of any employment in a particular setting; b) a school, college or university in order to enter onto school property or a particular location regardless of purpose; or c) a governmental body or agency for public surveillance purposes; and that does not relate to the furnishing or administration of an individualized test, screening or evaluation determined by your attending professional provider as being medically appropriate.
- for any other medical or dental service or treatment except as provided herein.

How Your Program Works - Dental Program

Choice of Provider

You may choose any licensed dentist for services. However, if you choose a network dentist, you limit your out of pocket costs. Network dentists limit their fees to their contracted maximum allowable charges for covered services. Also, if agreed by the provider, network dentists limit their charges for all services delivered to you, even if the service is not covered for any reason and a benefit is not paid under your dental program. Network dentists also complete and send claims for the covered services you receive directly to Highmark for processing. To find a network dentist, visit Highmark's Web site at www.myHighmark.com or call the toll-free number on the back of your dental identification card.

If you go to a dentist who is an out-of-network dentist, you may have to pay the dentist at the time of service and complete and submit your own claims to Highmark for reimbursement. You will be responsible for the dentist's full charge which may exceed Highmark's maximum allowable charge and result in higher out of pocket costs.

General Information - Dental Program

Who is Eligible for Coverage

You may enroll your:

- Spouse under a legally valid existing marriage
- Children under 26 years of age, unless otherwise extended pursuant to applicable state or federal law, including:
 - Newborn children
 - Stepchildren
 - Children legally placed for adoption
 - Legally adopted children or children for whom the member or the member's spouse is the child's legal guardian
 - Children awarded coverage pursuant to an order of court

An eligible dependent child's coverage automatically terminates and all benefits hereunder cease at the end of the month the dependent reaches the limiting age or ceases to be an eligible dependent as indicated above, whether or not notice to terminate is received by Highmark.

- Unmarried children over age 26 who are not able to support themselves due to intellectual disability, physical disability, mental illness or developmental disability. Highmark may require proof of such disability from time to time.

NOTE: To the extent mandated by the requirements of Pennsylvania Act 83 of 2005, eligibility will be continued past the limiting age for unmarried children who are enrolled as dependents under their parent's coverage at the time they are called or ordered into active military duty. They must be a member of the Pennsylvania National Guard or any reserve component of the armed forces of the United States, who is called or ordered to active duty, other than active duty for training, for a period of 30 or more consecutive days, or be a member of the Pennsylvania National Guard ordered to active state duty for a period of 30 or more consecutive days. If they become a full-time student for the first term or semester starting 60 or more days after their release from active duty, they shall be eligible for coverage as a dependent past the limiting age for a period equal to the duration of their service on active duty or active state duty.

For the purposes of this note, full-time student shall mean a dependent who is enrolled in, and regularly attending, an accredited school, college or university, or a licensed technical or specialized school for 15 or more credit hours per semester, or, if less than 15 credit hours per semester, the number of credit hours deemed by the school to constitute full-time student status.

A Member who takes a medically necessary leave of absence from school, or who changes his or her enrollment status (such as changing from full-time to part-time) due to a serious illness or injury may continue coverage for one (1) year from the first day of the medically necessary leave of absence or other change in enrollment, or, if earlier, until the date coverage would otherwise terminate under the terms of the Contract. The Plan may require a certification from the Member's treating physician in order to continue such coverage.

- A domestic partner shall be considered for eligibility as long as a domestic partnership (a voluntary relationship between two domestic partners) exists with you. In addition, the children of the domestic partner shall be considered for eligibility as if they were your children as long as the domestic partnership exists.

"Domestic Partner" means a member of a domestic partnership consisting of two partners, each of whom has registered with a domestic partner registry in effect in the municipality/governmental entity within

which the domestic partner currently resides, or who meets the definition of a domestic partner as defined by the state or local government where the individual currently resides or meets all of the following:

- Is unmarried, at least 18 years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time
- Is not related to the other partner by adoption or blood
- Is the sole domestic partner of the other partner and has been a member of this domestic partnership for the last six months
- Agrees to be jointly responsible for the basic living expenses and welfare of the other partner
- Meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for domestic partnerships which are currently enacted, or which may be enacted in the future

To be eligible for dependent coverage, proof that dependents meet the above criteria may be required.

Changes in Membership Status

In order for there to be consistent coverage, you must keep your benefits department informed about any address changes or changes in family status (births, adoptions, deaths, marriages, divorces, etc.) that may affect your coverage.

Your newborn child may be covered under your program for a maximum of 31 days from the moment of birth. To be covered as a dependent beyond the 31-day period, the newborn child must be enrolled as a dependent under this program within such period.

Leave of Absence or Layoff

Upon your return to work following a leave of absence or layoff that continued beyond the period of your coverage, your group's program may, in some cases, allow you to resume your coverage. You should consult with your plan administrator/employer to determine whether your group program has adopted such a policy.

Termination of Your Coverage Under the Group Contract

Your coverage can be terminated in the following instances:

- When you cease to be a student, your coverage will terminate at the end of the last month for which payment was made.
- When you fail to pay the required contribution, coverage will terminate at the end of the last month for which payment was made.
- Termination of the group contract automatically terminates the coverage of all the members. It is the responsibility of the group to notify you of the termination of coverage. However, coverage will be terminated regardless of whether the notice is given to you by the group.
- If it is proven that you obtained or attempted to obtain benefits or payment for benefits through fraud or intentional misrepresentation of a material fact, Highmark may, upon notice to you, terminate your coverage under the program.
- It is understood that you have an affirmative obligation to notify the group or Highmark as soon as the domestic partnership has been terminated. Upon termination of the domestic partnership, coverage of the former domestic partner and the children of the former domestic partner will terminate at the end of the last month for which payment was made.

Coordination of Benefits

If you or your dependents are covered by any other dental program and receive a service covered by this program and the other dental program, benefits will be coordinated. This means that one program will be primary and determine its benefits before those of the other program and without considering the other program's benefits. The other program will be secondary and determine its benefits after the primary program. The secondary program's benefits may be reduced because of the primary program's payment. Each program will provide only that portion of its benefit that is required to cover expenses. This prevents duplicate payments and overpayments. Upon determination of primary or secondary liability, this program will determine payment.

The following words and phrases regarding the Coordination of Benefits ("COB") provision are defined as set forth below:

- **Allowable Amount** is the program allowance for items of expense, when the care is covered at least in part by one or more programs covering the member for whom the claim is made.
- **Claim Determination Period** means a benefit year. However, it does not include any part of a year during which a person has no coverage under this program.
- **Other Dental Plan** is any form of coverage which is separate from this program with which coordination is allowed. **Other Dental Plan** will be any of the following which provides dental benefits, or services, for the following: group insurance or group type coverage, whether insured or uninsured. It also includes coverage other than school accident type coverage (including grammar, high school and college student coverages) for accidents only, including athletic injury, either on a 24-hour basis or on a "to and from school basis," or group or group type hospital indemnity benefits of \$100 per day or less.
- **Primary Plan** is the program which determines its benefits first and without considering the other program's benefits. A program that does not include a COB provision may not take the benefits of another program into account when it determines its benefits.
- **Secondary Plan** is the program which determines its benefits after those of the other plan (Primary Plan). Benefits may be reduced because of the other program's (Primary Plan) benefits.
- **Plan** means this document, providing dental care benefits to which this COB provision applies and which may be reduced as a result of the benefits of other dental plans.

The fair value of services provided by the Company will be considered to be the amount of benefits paid by the Company. The Company will be fully discharged from liability to the extent of such payment under this provision.

In order to determine which plan is primary, this Plan will use the following rules.

- If the other plan does not have a provision similar to this one, then that plan will be primary.
- If both plans have COB provisions, the plan covering the Member as a primary insured is determined before those of the plan which covers the person as a Dependent.
- Dependent Child/Parents Not Separated or Divorced -- The rules for the order of benefits for a Dependent child when the parents are not separated or divorced are:
 - The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
 - If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
 - The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;
 - If the other plan does not follow the birthday rule, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.

- Dependent Child/Separated or Divorced Parents -- If two or more plans cover a person as Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - First, the plan of the parent with custody of the child.
 - Then, the plan of the spouse of the parent with the custody of the child; and
 - Finally, the plan of the parent not having custody of the child.
 - If the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the Secondary Plan.
 - If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in the above paragraph, titled Dependent Child/Parents Not Separated or Divorced.

- Active/Inactive Member
 - For actively employed Members and their spouses over the age of 65 who are covered by Medicare, the plan will be primary.
 - When one contract is a retirement plan and the other is an active plan, the active plan is primary. When two retirement plans are involved, the one in effect for the longest time is primary. If another contract does not have this rule, then this rule will be ignored.

- If none of these rules apply, then the contract which has continuously covered the Member for a longer period of time will be primary.
- The plan covering an individual as a COBRA continuee will be secondary to a plan covering that individual as a Member or a Dependent.

Right to Receive and Release Needed Information -- Certain facts are needed to apply these COB rules. The Plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Any health information furnished to a third party will be released in accordance with federal law. Each person claiming benefits under this Plan must give any facts needed to pay the claim.

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

Right of Recovery -- If the payment made by the Plan is more than it should have paid under this COB provision, the Plan may recover the excess from one or more of the following: (1) persons it has paid or for whom it has paid; or (2) insurance companies; or (3) other organization. Members are required to assist the Company to implement this section.

Force Majeure

No failure, delay or default in performance of any obligation of Highmark shall constitute an event of default or breach to the extent that such failure to perform, delay or default arises out of a cause, existing or future, that is beyond the reasonable control and not the result of the negligence of Highmark. Such events include, by way of illustration and not limitation, Acts of God, war (declared or undeclared), government regulation, acts or inaction of governmental authority, civil or military authority, unforeseen disruptions caused by suppliers, subcontractors, vendors or carriers, terrorism, disaster, strikes, civil-disorder, curtailment of transportation

facilities, fire, floods, blizzards, epidemics, pandemics, viral or communicable disease outbreaks, National Emergency, quarantines, disruption of the labor force and/or any other cause which is beyond the reasonable control of Highmark (hereinafter a "Force Majeure Event"), that makes it impossible, illegal or commercially impracticable for Highmark to perform its obligations in whole or in part.

Upon the occurrence of a Force Majeure Event, Highmark shall take action to minimize the consequences of the Force Majeure Event. If Highmark relies on any of the foregoing as an excuse for failure, default or delay in performance, it shall give prompt written notice to the group of the facts that constitute such Force Majeure Event, when it arose and when it is expected to cease.

How to File a Claim - Dental Program

NOTICE OF CLAIM AND PROOF OF LOSS

Network Providers have directly or indirectly entered into an agreement with the Plan pertaining to the payment for Covered Services rendered to a Member. When a Member receives Covered Services from a Network Provider, it is the responsibility of the Network Provider to submit its claim to the Plan in accordance with the terms of its participation agreement. Should the Network Provider fail to submit its claim in a timely manner or otherwise satisfy the Plan's requirements as they relate to the filing of claims, the Member will not be liable and the Network Provider shall hold the Member harmless relative to payment of the Covered Services received by the Member.

When Covered Services are received from other than a Network Provider, the Member is responsible for submitting the claim to the Plan. In such instances, the Member must submit the claim in accordance with the following procedures:

1. **Notice of Claim**

The Plan will not be liable for any claims under this Contract unless proper notice is furnished to the Plan that Covered Services in this Contract have been rendered to a Member. Written notice of a claim must be given to the Plan within twenty (20) days or as soon as reasonably possible after Covered Services have been rendered to the Member. Notice given by or on behalf of the Member to the Plan that includes information sufficient to identify the Member that received the Covered Services shall constitute sufficient notice of a claim to the Plan. The Member can give notice to the Plan by writing to the Member Service Department. The address of the Member Service Department can be found on the Member's Identification Card. A charge shall be considered Incurred on the date a Member receives the Service for which the Charge is made.

2. **Claim Forms**

Proof of loss for benefits under this Contract must be submitted to the Plan on the appropriate claim form. The Plan, upon receipt of a notice of a Claim will, within fifteen (15) days following the date a notice of a claim is received, furnish to the Member claim forms for filing proofs of loss. If claim forms are not furnished within fifteen (15) days after the giving of such notice, the Member shall be deemed to have complied with the requirements of this Subsection as to filing a proof of loss upon submitting, within the time fixed in this Subsection for filing proofs of loss, itemized bills for Covered Services as described below. The proof of loss may be submitted to the Plan at the address appearing on the Member's Identification Card.

3. **Proof of Loss**

Claims cannot be paid until a written proof of loss is submitted to the Plan. Written proof of loss must be provided to the Plan within twelve (12) months after the date of such loss. Proof of loss must include all data necessary for the Plan to determine benefits. Failure to submit a proof of loss to the Plan within the time specified will not invalidate or reduce any Claim if it is shown that the proof of loss was submitted as soon as reasonably possible, but in no event, except in the absence of legal capacity, will the Plan be required to accept a proof of loss later than one (1) year from the time proof is otherwise required.

4. **Submission of Claim Forms**

The completed claim form, with all itemized bills attached, must be forwarded to the Plan at the address appearing on the Member's Identification Card in order to satisfy the requirement of submitting a written proof of loss and to receive payment for benefits provided under this Contract.

To avoid delay in handling Member-submitted claims, answers to all questions on the claim form must be complete and correct. Each claim form must be accompanied by itemized bills showing:

Person or organization providing the Service
Type of Service
Date of Service
Amount charged
Name of patient

Itemized bills cannot be returned.

A request for payment of a Claim will not be reviewed and no payment will be made unless all of the information and evidence of payment required on the Claim form has been submitted in the manner described above. The Plan reserves the right to require additional information and documents as needed to support a claim that a Covered Service has been rendered.

Notice of the Plan's claim determination will be issued within a reasonable period of time not to exceed thirty (30) days following the receipt of a proper proof of loss. This period of time may be extended one (1) time by the Plan for an additional period of time not to exceed fifteen (15) days provided the extension is due to matters outside the control of the Plan and a written explanation for the delay is provided to the Member.

In the event that the Plan renders an adverse decision on the Claim, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement describing the right of the Member to file an appeal.

5. **Time of Payment of Claims**

Claim payments for benefits payable under this Contract will be processed immediately upon receipt of a proper proof of loss.

6. **Authorized Representative**

Nothing in this Subsection shall preclude a duly authorized representative of the Member from filing or otherwise pursuing a Claim on behalf of the Member. The Plan reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of the Member.

Predetermination

A predetermination is a review in advance of treatment by Highmark to determine patient eligibility and coverage for planned services. Predetermination is not required to receive a benefit for any service under the program. However, it is recommended for extensive, more costly treatment such as crowns and bridges. A predetermination gives you and your dentist an estimate of your coverage and how much your share of the cost will be for the treatment being considered.

To have services predetermined, you or your dentist should submit a claim showing the planned procedures but leaving out the dates of services. Be sure to sign the predetermination request. Substantiating material such as radiographs and periodontal charting may be requested by Highmark to estimate benefits and coverage. We will determine benefits payable, taking into account exclusions and limitations including alternate treatment options based upon the provisions of the program. We will notify you of the estimated benefits.

When the services are performed, simply have your dentist contact us or fill in the dates of service for the completed procedures on the predetermination notification and re-submit it to Highmark for processing. Any predetermination amount estimated is subject to continued eligibility of the patient. We may also make adjustments at the time of final payment to correct any mathematical errors, apply coordination of benefits, and comply with your plan in effect and remaining program maximum dollars on the date of service.

Your Explanation of Benefits Statement

When you submit a claim, you will receive an Explanation of Benefits (EOB) statement that lists:

- the provider's actual charge;
- the allowable amount as determined by Highmark;
- the copayment; deductible and coinsurance amounts, if any, that you are required to pay;
- total benefits payable; and
- the total amount you owe.

Review of Claim Determination

If you are not satisfied with a claim determination or payment, please contact member service at the toll-free telephone number on your dental identification card. If, after speaking with a member service representative, you are still dissatisfied then please see the Appeal Procedure subsection below.

Filing Benefit Claims

- ***Authorized Representatives***

You have the right to designate an authorized representative to file or pursue a request for reimbursement or other post-service claim on your behalf. Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

- ***Requests for Reimbursement and Other Claims***

When you receive services from a network provider, the provider will report the services to Highmark and payment will be made directly to the provider. Highmark will also notify the provider of any amounts that you are required to pay in the form of a copayment. If you believe that the determination of the copayment amount is not correct or that any portion of those amounts are covered under your benefit program, you may file a claim to have that amount paid.

Determinations on Benefit Claims

Notice of Adverse Benefit Determinations Involving Requests for Reimbursement and Other Claims

If you have submitted a claim for services of an out-of-network provider, Highmark will notify you in writing of its determination on your request for reimbursement or other claim within a reasonable period of time following receipt of your claim. That period of time will not exceed 30 days from the date your claim was received. However, this 30-day period of time may be extended one time for an additional 15 days, provided that Highmark determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 30-day claim determination period. If an extension of time is

necessary because you failed to submit information necessary for Highmark to make a decision on your claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your claim.

If your request for reimbursement or other claim is denied, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal.

For a description of your right to file an appeal concerning an adverse benefit determination of a request for reimbursement or any other claim, see the Appeal Procedure subsection below.

Appeal Procedure

This appeal procedure is effective on the effective date of your program. If you are dissatisfied with our benefit determination on a claim, you may appeal our decision by following the steps outlined in this procedure. We will resolve your appeal in a thorough, appropriate, and timely manner to ensure that you are afforded a full and fair review of claims for benefits. Benefit determinations will be made in accordance with the plan documents and consistently among claimants. You or your authorized representative may submit written comments, documents, records and other information relating to claims or appeals. We will provide a review that takes into account all information submitted whether or not it was considered with its first determination on the claim. Any notifications by Highmark required under these procedures will be supplied to you or your authorized representative.

The following terms when used in this document have the following meaning:

- "Adverse benefit determination" is a denial, reduction, or termination of or failure to make payment (in whole or in part) based on a determination of eligibility to participate in a plan or the application of any utilization review; or a determination that an item or service otherwise covered is experimental or investigational or not dentally necessary or appropriate.
- "Authorized representative" is a person granted authority by you to act on your behalf regarding a claim for benefits or an appeal of an adverse benefit determination. An assignment of benefits is not a grant of authority to act on your behalf in pursuing and appealing a benefit determination.

Procedure

You or your authorized representative may file an appeal with Highmark within 180 days of receipt of an adverse benefit determination. To file an appeal, telephone the toll-free number listed on your dental ID card. We will review the claim and notify you of our decision within 60 days of the request for appeal. Any dentist advisor involved in reviewing the appeal will be different from and not in a subordinate position to the dentist advisor involved in the initial benefit determination. Notice of the appeal decision will include the following in written or electronic form:

- the specific reason for the appeal decision;
- reference to specific plan provisions on which the decision was based;
- a statement that you are entitled to receive upon request and free of charge, reasonable accessibility to and copies of all relevant documents, records, and criteria including an explanation of clinical judgment on which the decision was based and identification of the dental experts;
- a statement of your right to bring a civil action under ERISA; and
- the following statement: "You and Highmark may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Member Service - Dental Program

Whether it's for help with a claim or a question about your benefits, you can call your Member Service toll-free telephone number on the back of your dental ID card or log onto Highmark's Web site, www.myHighmark.com. A Member Service representative can also help you with any coverage inquiry. Representatives are trained to answer your questions quickly, politely and accurately.

You can get the following information:

- Find network providers and where to access them
- Verify eligibility for yourself or your dependents
- Request an out-of-network provider reimbursement form
- Speak with a Member Service representative
- Initiate an appeal of a benefit denial
- Ask any questions about your dental benefits

How We Protect Your Right to Confidentiality

We have established policies and procedures to protect the privacy of our members' protected health information ("PHI") in all forms, including PHI given verbally, from unauthorized or improper use. Some of the ways we protect your privacy include not discussing PHI outside of our offices, e.g., in hallways, elevators, as well as verifying your identity before we discuss PHI with you over the phone. As permitted by law, we may use or disclose protected health information for treatment, payment and health care operations, such as: claims management, routine audits, coordination of care, quality assessment and measurement, case management, utilization review, performance measurement, customer service, credentialing, medical review and underwriting. With the use of measurement data, we are able to manage members' health care needs, even targeting certain individuals for quality improvement programs, such as health, wellness and disease management programs.

If we ever use your protected health information for non-routine uses, we will ask you to give us your permission by signing a special authorization form, except with regard to court orders and subpoenas.

You have the right to access the information your doctor has been keeping in your medical records, and any such request should be directed first to your network physician.

You benefit from the many safeguards we have in place to protect the use of data we maintain. This includes requiring our employees to sign statements in which they agree to protect your confidentiality, using computer passwords to limit access to your protected health information, and including confidentiality language in our contracts with physicians, hospitals, vendors and other health care providers.

Our Privacy Department review and approves policies regarding the handling of confidential information.

Recognizing that you have a right to privacy in all settings, we even inspect the privacy of examination rooms when we conduct on-site visits to physicians' offices. It's all part of safeguarding the confidentiality of your protected health information.

Terms You Should Know - Dental Program

Claim - A request for payment or reimbursement of the charges or costs associated with a covered service.

Cosmetic - Those procedures which are undertaken primarily to improve or otherwise modify your appearance.

Dentist - A person licensed to practice dentistry in the state in which dental services are provided. Dentist will include other duly licensed dental practitioners under the scope of the individual's license when state law requires independent reimbursement of such practitioners.

Dentally Necessary - A dental service or procedure is determined by a dentist to either establish or maintain a patient's dental health based on the professional diagnostic judgment of the dentist and the prevailing standards of care in the professional community. The determination will be made by the dentist in accordance with guidelines established by Highmark.

Designated Agent - An entity that has contracted with Highmark, either directly or indirectly, to perform a function and/or service in the administration of this program.

Experimental or Investigative - The use of any treatment, procedure, facility, equipment, drug, or drug usage device or supply which Highmark determines is not acceptable standard dental treatment of the condition being treated, or any such items requiring federal or other governmental agency approval which was not granted at the time the services were rendered. Highmark will rely on the advice of the general dental community including, but not limited to dental consultants, dental journals and/or governmental regulations, to make this determination.

Limitations - The maximum frequency or age limit that applies to a covered service.

Maximum Allowable Charge - The greatest amount Highmark will allow for a specific service. Maximum allowable charges may vary depending upon the contract between Highmark or its designated agent and the particular network dentist rendering the service. Depending upon your program, maximum allowable charges for covered services rendered by out-of-network dentists may be the same or higher than such charges for covered services rendered by network dentists in order to help limit your out-of-pocket costs when you choose out-of-network dentists.

Member(s) - The policyholder and dependent eligible and enrolled for coverage under this program.

Network Dentist - A dentist who has executed a Participating Dentist Agreement with Highmark or its designated agent, under which the dentist agrees to accept Highmark's maximum allowable charge as payment in full for covered services. Network dentists separately agree to limit their charges for any other services delivered to you.

Out-of-Network Dentist - A dentist who has not entered into an agreement, directly or indirectly, with Highmark or its designated agent pertaining to payment for covered services rendered to a member.

Plan - Refers to Highmark, which is an independent licensee of the Blue Cross Blue Shield Association. Any reference to the plan may also include its designated agent as defined herein and with whom the plan has contracted, either directly or indirectly, to perform a function or service in the administration of this program.

Service - A service, treatment or supply rendered by a dentist to you.

Waiting Period - The period of time, if applicable, that you must be enrolled under the program before benefits will be paid for certain covered services.

Highmark is a registered mark of Highmark Inc.

You are hereby notified, your health care benefit program is between the Group, on behalf of itself and its members and Highmark Blue Cross Blue Shield. Highmark Blue Cross Blue Shield is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield companies throughout the United States. Although all of these independent Blue Cross and Blue Shield companies operate from a license with the Association, each of them is a separate and distinct operation. The Association allows Highmark Blue Cross Blue Shield to use the familiar Blue Cross and Blue Shield words and symbols. Highmark Blue Cross Blue Shield shall be liable to the Group, on behalf of itself and its members, for any Highmark Blue Cross Blue Shield obligations under your health care benefit program.

Summary of Benefits:

Blue Edge Dental Preferred

CMU Student Plan

Blue Edge Dental Preferred plan options provide you maximum cost savings. Benefits are increased when participating dentists are utilized. The listed percentages represent the portion of the maximum allowable charge (MAC) for which the plan is responsible. Network providers agree to accept the MAC as payment in full and agree to file your claims. **If you receive covered services from an out-of-network provider, the plan will apply the out-of-network percentages for covered services and you will be responsible for the difference, up to the provider's charge.** Standard deductibles, exclusions and limitations apply. Network dentists may elect to discount non-covered services and services above the annual maximum. Discounts vary by service and region and when agreed to by the provider; not permitted in all jurisdictions.

Carnegie University Student Health Plan - Blue Edge Dental Preferred 10W (Custom)		
	In-Network	Out-of-Network
Network	Elite Plus	90th Percentile
Deductible – Individual/Family (waived for In and Out-of-network Class I services)	\$100 / \$300	\$125 / \$375
Benefit Period Maximum per member	\$1,000	
Class I Services		
Exams	100%	80%
X-rays (bitewing and panoramic)	100%	80%
Cleanings	100%	80%
Fluoride Treatment	100%	80%
Sealants	100%	80%
Class II Services		
X-rays (all other)	80%	70%
Palliative Treatment (Emergency)	80%	70%
Basic Restorative (Fillings), Posterior Resins	80%	70%
Periodontics (Surgical and Nonsurgical) (No osseus surgery)	80%	70%
Oral Surgery (including Simple and Surgical Extractions) (No bony impacted extractions)	80%	70%
Endodontics (root canals on anterior and bicuspids only)	80%	70%
Class III Services		
Inlays, Onlays, Crowns	50%	50%
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures	50%	50%
Prosthetics (Bridges, Dentures)	50%	50%
Endodontics (root canals on molars)	50%	50%
Periodontics (osseus surgery)	50%	50%
Oral Surgery (partial and full bony impactions)	50%	50%
General Anesthesia	50%	50%
Space Maintainers	50%	50%
Orthodontics (dependents to age 19) (Deductible does not apply)		
Diagnostic, Active, Retention Treatment	Not Covered	Not Covered
Orthodontic Lifetime Maximum per covered dependent	Not Applicable	
Implants		
Implant Surgery, Supported Restoration	Not Covered	
Additional Features		
<input type="checkbox"/> TMD/TMJ*	<input checked="" type="checkbox"/> Smile for Health®--Wellness	<input checked="" type="checkbox"/> Pregnancy
<input type="checkbox"/> Annual Maximum Rollover*	<input checked="" type="checkbox"/> Occlusal Guard*	<input type="checkbox"/> Preventive Incentive*

Highmark Inc. d/b/a Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's benefits or benefit administration and/or to one or more of its affiliated Blue companies.

United Concordia is a separate company that provides the provider network for Blue Edge Dental and administers dental benefits.

Summary of Standard Benefits:

Blue Edge Dental

This is an abbreviated list of Highmark's Standard Benefits and their Limitations. Please refer to your specific benefit design as to what services are covered under your plan.

Blue Edge Dental	
Benefit Category	Highmark's Standard Benefit Frequency Limitations
Exams	2 per calendar year
X-rays (Bitewings Only)	1 set every 12 months under age 19 and one set every 18 months age 19 and over
X-rays (All Others)	1 every 5 years for Full Mouth and Panoramic X-rays Limitations may apply to other types of X-rays
Cleanings	3 per calendar year (1 every 6 months during the calendar year)
Fluoride Treatment	1 per calendar year under the age of 14
Sealants	1 per tooth every 3 years to age 16 on permanent first and second molars
Space Maintainers	1 every 5 years under the age 14
Palliative Treatment (Emergency)	2 per 12 months in combination with pulpal debridement
Basic Restorative	Not within 24 months of previous placement. Includes coverage for posterior resins
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures	1 per 36 months
Simple Extractions	Any frequency (no limitations)
Complex Oral Surgery	May vary by procedure
General Anesthesia	Limited to 60 minutes per session
Endodontics	Pulpal therapy: primary teeth that have no permanent tooth to replace it Root canal treatment: 1 per tooth per lifetime
Periodontics (Nonsurgical)	Full mouth debridement: 1 per lifetime Scaling and root planing: 1 per 36 months (per area of mouth) Periodontal maintenance: 2 per calendar year (in addition to routine prophylaxis following active periodontal therapy)
Periodontics (Surgical)	Surgical periodontal procedures: 1 per 36 months (per area of mouth) Guided tissue regeneration: 1 per tooth per lifetime
Inlays, Onlays, Crowns	Not within 5 years of previous placement
Prosthetics (Bridges, Dentures)	Not within 5 years of previous placement
Implants	Age 18 and older and 1 per tooth per lifetime
Orthodontics (dependents to age 19)	Payment for orthodontic services, if covered, shall cease at the end of the month after termination by the Company.
Diagnostic, Active, Retention Treatment	
Alternative Benefit Provision	An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed under this ABP.
Blue Edge Dental Rider Options (Please refer to your specific benefit design as to what services are covered under your plan.)	
Smile for Health®--Wellness <i>Provides periodontal care for people with certain chronic medical conditions: diabetes, heart disease, lupus, oral cancer, organ transplant, rheumatoid arthritis, stroke and head or neck radiation</i>	Not Covered
Pregnancy Benefit	Covers 1 additional cleaning during pregnancy in addition to the benefits listed for Smile for Health®--Wellness
Preventive Incentive	Not Covered
Annual Maximum Rollover	Not Covered
Occlusal Guard	<ul style="list-style-type: none"> 1 per 60 months for members 22 years and older after a 6 month waiting period Covered at 50% \$1,000 Lifetime maximum
Temporomandibular Disorder (TMD/TMJ)	Not Covered

Effective 1/1/2026

NOTICE OF PRIVACY PRACTICES

Highmark Inc.



Your Information. Your Rights. Our Responsibilities.

THIS NOTICE DESCRIBES HOW HEALTH AND FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND SHARED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Our responsibilities

At Highmark Inc., including its wholly-owned health plan subsidiaries and affiliates (Highmark), we value your privacy. When it comes to managing your information, we are required by law to maintain the privacy and security of your health and non-public personal (financial) information and to provide you with notice of your rights and our duties to keep your information safe and confidential. This Notice of Privacy Practices ("Notice") combines two required privacy notices:

- Health Insurance Portability and Accountability Act (HIPAA) notice of privacy practices
- Gramm Leach Bliley Act (GLBA) privacy notice

In the normal course of doing business, we collect information as necessary to provide you with health insurance products, help manage the treatment you receive, pay for your health services, and to run our business. The information we collect is called Protected Health Information ("PHI"). PHI is health and financial information that identifies you, or could be used to identify you, and was created or received by a health care provider, a health plan, a health care clearinghouse, or vendor performing activities on behalf of one of these organizations, or your employer (if a group health plan), and is related to one of the following:

- Your past, present, or future physical or mental health or condition;
- Providing you with health care; and,
- The past, present, or future payment for providing you with health care.

This Notice describes our privacy practices, which includes how we use, disclose (share), collect, manage, and protect your PHI and other non-public personal information. This Notice applies to all electronic and paper records we create, obtain, or maintain about you as a member, as well as all forms of communication (oral, written, and electronic) of this information. This Notice does not apply to Highmark in the context of being an employer.

How we protect your privacy

We understand the importance of protecting the confidentiality of your information. We restrict access to your PHI and personal information to those employees, agents, consultants, and health care providers who need to know the information to provide products or services. We maintain physical, electronic, and procedural safeguards that comply with state and federal regulations to protect personal information against unauthorized use, access, and disclosure. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your PHI or non-public personal information.

How we use and share your information

We use and share PHI and other non-public personal information we collect only as necessary to deliver products and services to our members, to operate our business, or to comply with legal requirements. For example, we may use your PHI and non-public personal information internally to manage enrollment, process claims, or audit our operations. We share PHI and non-public personal information with our affiliated companies and non-affiliated third parties, as permitted

by law, who assist us in administering our programs, coordinating care, and delivering products and services to our members. We may also share PHI and non-public personal information with other third-party service providers that cooperate with us to jointly promote or administer health insurance products or services. Our contracts with all such service providers require them to protect the confidentiality of our members' information.

Please be advised that once information is shared with a third party other than a health care provider, health plan, or other person subject to federal privacy laws – for example, if you fill out an authorization form directing us to share your PHI with a life insurance carrier – the information may no longer be subject to privacy and security protections, and the recipient may use or share that information for other purposes.

Uses of PHI without your authorization.

We have the right to collect, use, and share your PHI, if needed, without your written authorization while providing your health benefits. We have listed a few examples of how we use your information without authorization.

- **Help manage the health care you receive:** To manage the health care you receive, we can use your PHI and share it with health care professionals that are treating you. For example, a doctor sends us information about your diagnosis and treatment plan so we can arrange additional services or assess the quality of your care.
- **Pay for your health services:** We may use and share your PHI as we pay for your health services. For example, we share information about you with your health care provider to coordinate payment for your particular treatment.
- **Run our business:** We may use and share your PHI to run our business and contact you when necessary. For example, we use information about you to develop and enhance products and services offered to our members, and we may share your information among our subsidiaries and affiliated entities for purposes permitted by applicable law.
- **Administer your benefits:** We may share your PHI with your group health plan administrator to perform administrative functions for the benefit plan in which you participate. For example, your employer contracts with us to administer health coverage, and we provide your employer's plan administrator with certain information to explain the premiums we charge, or to enroll or disenroll members in the benefit plan.

We may collect, use, and share your information in other ways without your authorization. We must meet certain conditions in the law before we can share your information for these purposes. The following are some of those examples.

- **As required by law:** We may share your PHI if federal or state law requires the use or disclosure. For example, we must share your PHI with the U.S. Department of Health and Human Services if they want to see that we are following federal privacy laws.
- **Help with public health and safety issues:** We can share your PHI for certain situations such as:
 - Preventing or controlling disease, injury, or disability;
 - Reporting abuse, neglect, or domestic violence;
 - Helping with product recalls;
 - Reporting adverse reactions to medications;
 - Preventing or reducing a serious threat to anyone's health or safety.
- **Respond to lawsuits and legal actions:** We may share your PHI in response to certain legal requests. For example, we may share your PHI in response to a court order, administrative order, or subpoena that complies with applicable law.
- **Respond to requests from coroners, medical examiners, funeral directors, and organ donation agencies:** We may share PHI with a coroner or medical examiner to identify deceased persons and the cause of death. If necessary, we will share PHI with funeral directors. Further, we may share PHI with organizations that handle organ, eye, or tissue donation and transplantation.
- **Do research:** We can use or share your information for health research purposes, subject to certain criteria.

- **Address workers' compensation, law enforcement, health oversight activities, and other government requests:** We can use or share your PHI when needed:
 - For workers' compensation claims;
 - For law enforcement purposes or with a law enforcement official;
 - With health oversight agencies for activities authorized by law;
 - For special government functions such as military, national security, and presidential protective services.
- **Cookies and Online Services:** We may collect information obtained when you visit and utilize Highmark websites (including the Highmark Member Portal or other online benefit sites) or mobile device applications. Through the use of cookies, pixels, and other digital tracking technologies, we may collect and share information about your use of these digital services, pursuant to applicable laws, to operate our business and improve our product and service offerings.
- **Underwriting Purposes:** We may use or disclose PHI for underwriting purposes, but we are prohibited from pricing your coverage or denying you coverage based on genetic information.
- **Business Associates:** We may contract with outside entities that perform business services for us that may require them to use or access your PHI. These entities are called business associates. We will have a written contract in place with the business associate requiring protection of the privacy and security of your health information. For example, we may share your PHI with a business associate to analyze your use of our websites and mobile device applications including, but not limited to, access times, pages viewed, etc. We may also use your PHI to develop, operate, and improve machine learning and other artificial intelligence solutions, for example, to support transcription of customer service calls or claims processing. You should review our Digital Privacy Policy (available on our website) and any applicable Terms of Use for supplemental details regarding our online services, the information we collect, and the terms associated with a particular website or application.
- **Health Information Exchange (HIE):** We may participate in certain Health Information Exchanges (HIEs), which may be an opt-in or opt-out model. An HIE is a secure electronic data sharing network which allows us to share health information electronically with other healthcare entities, such as insurers, health systems, hospitals, and physicians participating in your care for the purposes of treatment, payment, and healthcare operations. The health information we may share includes your claims, medical history, diagnosis, notes, test results, current medications, allergies, immunizations, and other vital information needed for your care. All providers who participate in an HIE have agreed to privacy and security rules to protect your health information from unauthorized access, use or disclosure.

You cannot choose to have only certain providers access your information. If you do not want your health information to be accessed through an HIE, you may choose not to participate or "opt-out" where applicable. Even if you opt-out, this will not prevent your health information from being shared in other ways as authorized or allowed by law for purposes such as managing your health care, paying claims for services you received, or administering your benefits.
- **Organized Health Care Arrangement (OHCA):** Highmark and its affiliated system of healthcare providers, Allegheny Health Network (AHN), participate in an OHCA to conduct analysis for quality assessment and improvement activities, utilization review and related activities to facilitate more effective and efficient health care services for our members and patients. Individual PHI may be accessed, used and/or disclosed as necessary to carry out treatment, payment, or health care operations relating to the OHCA.
- **Inmates.** If you are an inmate of a correctional institution, we may share your PHI with the correctional institution to provide you with health care, or to protect your health and safety or the health and safety of others.

Uses of PHI that require your authorization. Sometimes we are required to obtain your written authorization for the use and disclosure of your PHI. For example, we would need your authorization:

- To use your PHI for certain marketing purposes;
- To sell your information;

- To share your substance use disorder counseling notes; and
- To share your psychotherapy notes.

Withdrawal. We will not use or share your information other than as described in this Notice, or as permitted or required by applicable law, unless you tell us we can in writing. You may change your mind at any time by letting us know in writing. Any change or withdrawal of authorization will be effective for future uses and disclosures of PHI. It will not impact use of information or disclosures that we have already made while your previous authorization was in effect.

Compliance with State and Federal laws. We are required to comply with federal and state laws when they offer greater privacy protection for certain types of PHI. Where such laws apply, we will follow the stricter laws related to the use and sharing of sensitive PHI, such as:

- Genetic information;
- HIV/AIDS testing, diagnosis, or treatment;
- Venereal or communicable disease testing, diagnosis, or treatment;
- Alcohol or drug abuse prevention, treatment, and referral;
- Psychotherapy notes.

Your personal information

We may also collect, use, and share other non-public personal information to administer our health and benefit programs. Personal information identifies you and may include such items as your name, address, telephone number, date of birth and Social Security number, or it may relate to health care services or premium payment history. We collect your personal information either directly from you or from others such as doctors, hospitals, or other insurers, as applicable. In some cases, we may also share your personal information with third parties and without your authorization as permitted or required by law. If sharing your personal information for a specific reason requires us to give you a chance to opt-out, we will give you that opportunity.

Your choices

For certain health information, you can tell us your choices about what we share. We may use and share your information in the situations described below but you have the right to limit or object to sharing information for these reasons.

- Under certain circumstances, we may share your PHI with your family or close friends that you have identified as being involved in your health care or payment for your health care, unless you tell us not to do so. If you are unable to provide us permission, then we may provide the information we determine is in your best interest based on our professional judgement.
- We may share your information in a disaster relief situation.
- We may use or share your name, address, phone number, and the dates you received services to contact you to support our fundraising efforts, consistent with applicable laws.

Your individual rights

When it comes to your health information, you have certain rights. The following is a description of those rights. Any request must be in writing and signed by you or your authorized representative. You can obtain more information about how to submit your request by calling the Customer Service phone number on the back of your identification card. You may also request more information or submit your request in writing to the contact listed at the end of this Notice.

- **Get a copy of your health and claims records:** You can ask to review or receive copies of your health and claims records that we have about you in a designated record set. We will provide a copy or summary of your health and claims records. We may charge a reasonable cost-based fee.

- **Get a list of those with whom we have shared information:** You can ask for a list (an “accounting”) of the times we have shared your PHI that are for reasons other than treatment, payment, health care operations, or those which you authorized. You may request the date range you want to review; however, this is limited to 6 years before the date of your request.
- **Ask us to limit what we use or share:** You can ask us not to use or share certain health information about you for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it is not consistent with the law, our policies, or our business operations.
- **Request confidential communications:** You can ask us to contact you in a specific way, or at a different address, if you believe that sharing your PHI could place you in danger. For example, you may ask that we contact you only at your work address or your work email.
- **Ask us to correct or amend health and claims records:** You can ask us to correct, or amend, your health and claims records if you believe they are incorrect or incomplete. Your request must explain why you believe the information needs to be corrected. We may say “no” to your request, but we will tell you why in writing.
- **Choose someone to act for you:** If you have given someone medical power of attorney or if someone is your legal guardian or other authorized representative, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- **Get a paper copy of this Notice:** You can ask for a paper copy of this Notice, even if you have agreed to receive the Notice electronically.

Changes to the terms of this Notice

On an ongoing basis, it may become necessary to revise the terms of this Notice. Any changes will apply to all information we have about you. If the Notice significantly changes, the new Notice will be available upon request, on our website, and we will mail a copy to you in our annual mailing.

Complaints

If you want more information about our privacy practices or are concerned that we may have violated your privacy rights, you can complain to us using the following contact information:

Privacy Operations
 120 Fifth Avenue Place, Suite 2114
 Pittsburgh, PA 15222
 Toll free: 1.800.985.2050

HighmarkHealthPrivacy@highmarkhealth.org

You may also file a complaint with the U.S. Department of Health and Human Services by using the following contact information:

U.S. Department of Health and Human Services
 Office for Civil Rights
 200 Independence Avenue, S.W.
 Washington D.C. 20201
 Toll free: 1.877.696.6775
www.hhs.gov/ocr/privacy/hipaa/complaints.

We support your right to protect the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Effective date

We must follow the privacy practices described in this Notice while it is in effect. This Notice is revised and effective as of September 2025 and will remain in effect unless we replace it.

ADDITIONAL PROVISIONS: PRIVACY PRACTICES RELATED TO SUBSTANCE USE DISORDER (SUD) RECORDS

These additional provisions to this Notice apply only to federally regulated SUD records. Your SUD records will be protected by federal and state privacy laws. Unless specifically indicated in these additional provisions, your SUD records will have the same protections and you will have the same rights as described elsewhere in this Notice. The following provisions identify added protections for SUD records, as required by law.

When we can use and share your SUD records

For PHI collected by a SUD program governed by federal regulations, your consent will be obtained for all future uses or disclosures for treatment, payment, and healthcare operations before sharing such information consistent with applicable privacy laws. We may also obtain your consent to disclose SUD records to prevent multiple enrollments in withdrawal management or maintenance treatment programs, or to persons within the criminal justice system who have made participation in the substance use disorder program a condition of the disposition of any criminal proceedings against you or of your parole, or other release from custody, provided the disclosure is permitted by applicable privacy laws. In most cases, your consent is obtained for this when you begin treatment with a program covered under federal regulations. Except as described in these additional provisions, any other uses or disclosures of your SUD records will require your written consent.

Records that we share with your consent to a third party regulated by federal privacy laws may be further disclosed, without your written consent, by the third party, to the extent permitted by federal privacy laws.

We may use and share SUD records without your consent for the following reasons when all conditions required by federal law are met: medical emergencies, scientific research, management audits, financial audits, program evaluation, and disclosures to public health authorities when the health records are de-identified.

Prohibition on sharing records in civil, criminal, administrative or legislative proceedings

We will not use or share your SUD records (or provide testimony based on such information) in any civil, criminal, administrative, or legislative proceedings against you, unless you have provided your written consent, or a special type of court order has been obtained and you have had the opportunity to object.

Opt-out for fundraising

We will only use or share records to fundraise for the benefit of a SUD treatment program if you are first provided with an option to elect not to receive fundraising communications.

You can request to no longer receive fundraising communications following your participation in a SUD program, even if you initially permitted us to send such communications.

Disclosures:

*Benefits and/or benefit administration may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association:

Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life, Highmark Wholecare, or Highmark Senior Health Company.

Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company, Highmark Wholecare, or Highmark Senior Health Company.

PA: Your plan may not cover all your health care expenses. Read your plan materials carefully to determine which health care services are covered. For more information, call the number on the back of your member ID card or, if not a member, call 866-459-4418.

Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield or Highmark Health Options.

West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company, Highmark Health Options, or Highmark Senior Solutions Company. **Visit <https://www.highmarkbcbswv.com/networkaccessplan> to view the Access Plan required by the Health Benefit Plan Network Access and Adequacy Act. You may also request a copy by contacting us at the number on the back of your ID card.**

Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield.

Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

