ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY INDIVIDUAL ENHANCED TONIK[SM] PPO DENTAL PLAN

If you have any questions regarding your eligibility or membership please feel free to contact us toll free at (866) 333-4820 or you may write to us at:

Anthem Blue Cross Life and Health Insurance Company
P.O. Box 9051
Oxnard, California 93031-9051.

If you have any questions regarding claims status or your benefits under this Policy, please feel free to contact our dental customer service department toll free at (888) 209-7852 or write to us at:

Anthem Blue Cross Life and Health Insurance Company
P.O. Box 9066
Oxnard, CA 93031-9066.

Thank you for choosing Anthem Blue Cross Life and Health Insurance Company.

Leslie A. Margolin Chief Executive Officer Anthem Blue Cross Life and Health Insurance Company	Nancy L. Purcell Secretary Anthem Blue Cross Life and Health Insurance Company

Note: Coverage is provided by Anthem Blue Cross Life and Health Insurance Company, which is an affiliate of Anthem Blue Cross, and Anthem Blue Cross will administer your coverage for Anthem Blue Cross Life and Health Insurance Company.

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INDIVIDUAL ENHANCED TONIK PPO DENTAL PLAN

ISSUED BY

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

This booklet is called a Policy. It will tell you how your dental plan works, which dental services are covered and which services are not covered. It will tell you what your benefits are, when and how you have (and don't have) a right to these benefits. Please read your Policy completely and carefully. If you have special dental care needs, carefully read those sections that apply to you.

YOU HAVE THE RIGHT TO LOOK AT THIS POLICY PRIOR TO ENROLLMENT.

You can request a copy of the "Notice of Privacy Practices" which explains your rights. You can get a copy by checking our website at **tonikhealth.com** or by calling us at (888) 209-7852.

Dentists and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. For additional information you may contact our dental customer service department toll free at (888) 209-7852 or your Participating Dentist.

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY enters into this Policy with you. In consideration for the payment of the premiums stated in this Policy, We will provide the services and benefits listed in this Policy to you subject to all the terms, conditions, limitations and exclusions of this Policy.

In this Policy, "We", "us" and "our" mean Anthem Blue Cross Life and Health Insurance Company ("Anthem Blue Cross Life and Health" "Anthem"). "You," "your," or "Policyholder" means the eligible Policyholder whose enrollment application has been accepted by us.

IF YOU ARE UNDER THE AGE OF 18 YEARS, YOUR PARENT OR LEGAL GUARDIAN MAY NOT HAVE YOUR RIGHTS AS THE POLICYHOLDER, BUT YOUR PARENT OR LEGAL GUARDIAN WILL BE CONSIDERED THE RESPONSIBLE PARTY, AND, THEREFORE, WILL BE HELD LIABLE FOR ALL FINANCIAL AND/OR CONTRACTUAL OBLIGATIONS OF THIS POLICY UNTIL YOU ARE 18 YEARS OF AGE.

Note: This Policy covers the named Policyholder only and does not provide benefits for dependents, such as spouse, domestic partner, newborn, legal ward, and natural and/or adopted child. However, if you have a dependent, he or she may apply for coverage as a policyholder under his or her own separate policy. A completed application must be received by Anthem Blue Cross Life and Health if you are requesting coverage for a dependent. For dependents under the age of 18 years (including newborns), a parent or guardian must complete the application on behalf of the dependent.

THE BENEFITS OF THIS POLICY ARE PROVIDED ONLY FOR SERVICES THAT ARE CONSIDERED MEDICALLY NECESSARY. THE FACT THAT A DENTIST PRESCRIBES OR ORDERS THE SERVICE DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY OR A COVERED EXPENSE. CONSULT THIS POLICY OR TELEPHONE OUR DENTAL CUSTOMER SERVICE DEPARTMENT TOLL FREE AT (888) 209-7852 IF YOU HAVE ANY QUESTIONS REGARDING WHETHER SERVICES ARE COVERED.

The benefits of this Policy are intended for use in the State of California. Any benefits received for services performed out of the State of California may be significantly lower and result in a greater out-of-pocket expense for you.

If, within two (2) years after the Effective Date of this Policy, We discover any material facts that were omitted or that you knew, but did not disclose on your application, We may rescind this Policy as of the original Effective Date.

You have ten (10) days from the date of delivery to examine this Policy. If you are not satisfied, for any reason, with the terms of this Policy, you may return this Policy to us within those ten (10) days. You will then be entitled to receive a full refund of any premiums paid. This Policy will then be null and void.

CHOICE OF DENTIST: Nothing contained in this Policy restricts or interferes with your right to select the Dentist of your choice, **but your benefits are reduced when you use a Dentist who is not a Prudent Buyer Plan Participating Dentist.**

THE ENTIRE POLICY SETS FORTH, IN DETAIL, THE RIGHTS AND OBLIGATIONS OF BOTH YOU AND ANTHEM BLUE CROSS LIFE AND HEALTH. IT IS, THEREFORE, IMPORTANT THAT YOU READ YOUR ENTIRE POLICY CAREFULLY. PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS DENTAL CARE MAY BE OBTAINED.

BECAUSE WE CARE ABOUT THE QUALITY OF THE SERVICE PROVIDED TO OUR CUSTOMERS, YOUR TELEPHONE CALL TO US MAY BE RANDOMLY RECORDED TO MAKE SURE THAT THE PEOPLE YOU TALK TO ARE FRIENDLY AND HELPFUL.

IMPORTANT!

This is not an annual Policy. The duration of your coverage depends on the method of payment you chose under paragraph 2. under the Section entitled **Duration of your Policy**, and is not affected by any provisions defining your Deductible or other cost sharing obligations. Your Policy expires at the end of each billing cycle but will automatically renew upon timely payment of your next premium, subject to our right to terminate, cancel or non-renew as described in the Section entitled **How Your Coverage Ends**. Also, premiums, benefits, terms and conditions may be modified at any time during the year following thirty (30) days written notice pursuant to the Section entitled **Notice to Cancel or Cease Coverage and Our Right to Modify Your Policy**. Please read the Sections entitled **Duration of your Policy, How Your Coverage Ends and Notice to Cancel or Cease Coverage and Our Right to Modify Your Policy** carefully and in their entirety to make sure you fully understand the duration of your coverage and the conditions under which We can change, terminate, cancel or decline to renew your Policy.

PART 1 HOW TO USE YOUR DENTAL PLAN

Throughout this Policy, if you see a word or term which appears with the first letter of each word in capital letters, you can look up its definition in the back of this booklet under IMPORTANT TERMS TO KNOW.

Using Your ID Card

Your Anthem Blue Cross Life and Health identification (ID) card not only identifies you, but it also lists important phone numbers. Carry your ID card with you at all times and present it whenever you are having dental services. You can find your Effective Date of coverage on your ID card. This is the date your dental benefits start with us. You are the only person who can get dental services under this Policy. If you let someone else use your ID card, your coverage could be terminated.

Choosing Dentists

Please read the following information because the type of Dentist you choose will affect your payment responsibility.

Benefits are available in-network

This Anthem Blue Cross Life and Health Preferred Provider Organization (PPO) Plan gives you access to care through a network of Dentists. These in-network Dentists are called Participating Dentists. They contract with us to provide services to you at pre-negotiated discounted fees (called the Negotiated Fee Rate). Covered Expenses for Participating Dentists are based on this Negotiated Fee Rate. Participating Dentists have a Prudent Buyer Participating Dentist Agreement in effect with us and have agreed to accept the Negotiated Fee Rate as payment in full. Using Participating Dentists assures maximum savings for you. In addition, Participating Dentists will file your claims with us. For a directory of Participating Dentists or more information, visit our website or call us toll free at (888) 209-7852.

Benefits are still available out-of-network

You can still go to out-of-network Dentists (called Non-Participating Dentists) and receive benefits for Covered Services. However, Non-Participating Dentists do not have a Prudent Buyer Participating Dentists Agreement with us and you will pay a much greater share of the cost when you receive services from them. They may charge you whatever they like, but We will pay benefits only on the amount We say in this Policy that We will allow (Covered Expense) for Non-Participating Dentists. In addition to any Deductible, you will be responsible for any balance of a Dentist's bill which is above the allowed amount (Covered Expense) payable under this Policy for Non-Participating Dentists. Please read the benefit sections carefully to determine those differences.

Nothing contained in this Policy restricts or interferes with your right to select a Non-Participating Dentist. Payments of benefits under this Policy do not regulate the amounts charged by Dentists or attempt to evaluate those services.

Making an appointment with the Dentist

Call the Dentist's office for an appointment and tell them you are insured with us. Have your identification (ID) card with you when you call because you may be asked for the ID number on the card. If you're going to be late or you can't go to your appointment, call your Dentist's office as soon as possible. Your dental office may charge you a fee if you fail to cancel a scheduled appointment within a certain time frame. This charge is not reimbursable by us.

How To Submit a Claim

Participating Dentists will submit your claims to us. However, if you go to a Non-Participating Dentist either you or your Dentist must claim benefits by sending us properly completed claim forms itemizing the services or supplies received and the charges. Claim forms that you submit must be received by us within fifteen (15) months from the date the services or supplies are received. We will not be liable for benefits if a completed claim form is not furnished to us within this time period, except in the absence of the Policyholder's legal capacity. Claim forms must be used; canceled checks, statements, speed bills or receipts are not acceptable. You can request claim forms by calling us toll free at (888) 209-7852, or by writing to us. Use the following address to request claim forms or to send your completed claim forms:

Anthem Blue Cross Life and Health Insurance Company
P.O. Box 9066
Oxnard, CA 93031-9066

For information about how your plan works, including your Deductible, the yearly Maximum Benefit and Covered Expenses provided under this Policy, please see the PART called "WHAT IS COVERED".

PART 2 WHAT YOU SHOULD KNOW ABOUT YOUR COVERAGE

Who is Eligible for Coverage

A resident of the State of California who has properly applied for coverage and who is insurable according to our applicable underwriting requirements.

Only the named Policyholder is eligible for benefits under this Policy. Other persons, including, but not limited to, the Policyholder's dependents, such as spouse, domestic partner, newborn, legal ward, and natural and/or adopted child, **are not** eligible for coverage under this Policy.

Your Effective Date

The Effective Date of your coverage is printed on your Anthem Blue Cross Life and Health ID card which is issued together with this Policy and is a part of this Policy.

Monthly Premiums

The premiums printed on your individual rate sheet, which is included within and part of this Policy, are payable in advance and due the first of the month.

There are several billing options available:

- Monthly premium payments are an option if you pay with an automatic checking account deduction or credit card. If you do not select an automated billing method, you will receive a paper bill in the mail every 2 (two) months.
- Premium payments can be made over the phone from your checking account if you use "check by phone" or you can use your credit card.

You will be responsible for an additional $25 charge for any check or debit which is returned or dishonored by the bank as non-payable to us for any reason.

Important: If you are enrolled in an automated billing program, you must give us thirty (30) days advance written notice to:

- change banks or credit cards
- change account numbers
- change account names
- stop deduction, or
- re-start eligible deductions.

If We do not receive your written request at least thirty (30) days in advance of your premium due date, We will not be able to make the requested change in time to coincide with your premium due date. Just call us at (866) 333-4820.

Electronic Funds Transfer: If you receive billing statements by mail and you submit a personal check for premium payments, you automatically authorize us to convert that check into an electronic payment. We will store a copy of the check and destroy the original paper check. Your payment will be listed on your bank or credit union account statement as an Electronic Funds Transfer (EFT). Converting your paper check into an electronic payment does not authorize us to deduct premiums from your account on a monthly basis unless you have given us prior authorization to do so.

Premiums are established based on the specific regional area within which you live. If you move, (change where you reside) you may be subject to a change in premiums. Such change in premiums will be effective on the next billing date following written notification of the change of residence. If you do not notify us and We later learn of the change in residential address, We may adjust the premium retroactively. This means that We may bill you for any additional premium from the date your address changed.

We reserve the right to change the premiums on thirty (30) days written notice to you prior to the close of any billing term. The change will become effective on the date shown in the notice, and payment of the new premium will indicate acceptance of the change.

Please be sure to read this entire PART for additional terms and conditions.

This Policy will terminate without notice upon failure to pay premiums when due. A grace period of thirty-one (31) days will be allowed for the payment of premiums, and this Policy will remain in effect during that time. However, if necessary, We have the right to deduct the unpaid premiums from the payments for Covered Services.

Duration of your Policy

1. The Effective Date of your coverage is printed on your Anthem Blue Cross Life and Health identification card which is issued together with this Policy and is a part of this Policy.

2. The duration of your coverage under this Policy depends on how your premiums are billed, and is equal to the length of time between billing cycles. For example, if We bill premiums on a bi-monthly basis, your coverage is for a two-month duration. If We bill premiums on a quarterly basis, your coverage is for a three-month duration. If you have chosen our monthly checking account deduction program, or are a member of a list bill program, or if We otherwise bill premiums on a monthly basis, your coverage is for a one-month duration. The duration of the Policy is determined by how you pay your premiums (measured from the Effective Date of coverage) and is unrelated to, and is not affected by, the use of other periods of time to measure or determine your rights or benefits, such as, for example, the use of a calendar year or other Deductibles.

3. Although your Policy expires at the end of each billing cycle, it will, upon timely payment of the billed premiums, automatically renew under the same terms and conditions unless (1) We have terminated, canceled, or declined to renew the Policy pursuant to the section entitled **How Your Coverage Ends**; or (2) We have modified the Policy pursuant to the section entitled **Notice to Cancel or Cease Coverage and Our Right to Modify Your Policy** below. In the case of a modification under the section entitled **Notice to Cancel or Cease Coverage and Our Right to Modify Your Policy**, the Policy will renew for the term specified in paragraph 2. above under the modified terms and conditions.

How Your Coverage Ends

We may, at any time, terminate, cancel or decline to renew this Policy in the event of any of the following:

1. When your premium is not paid within the grace period. The grace period for payment of future premiums is thirty-one (31) days. If you fail to pay premiums as they become due, We may terminate this Policy as of the last day of the grace period described above. Nevertheless, We will terminate this Policy only upon first mailing you a written notice of cancellation at least fifteen (15) days prior to that termination.

The notice of cancellation shall state that this Policy shall not be terminated if you make appropriate payment in full within fifteen (15) days after We issue the notice of cancellation. You are not entitled to a grace period until you have made your first payment to us. If you need covered benefits during the grace period, coverage will be provided. However, We will deduct the premiums due for coverage continued during the grace period from any benefits We pay.

The notice of cancellation also shall inform you that, if this Policy is terminated for non-payment of premiums, you may apply for reinstatement by submitting a new application and any premiums that are owed. See the section REINSTATEMENT in the PART called **IMPORTANT INFORMATION ABOUT YOUR PLAN**, for the reinstatement provision.

2. On the first of the month following our receipt of your written notice to cancel.

3. For fraud or misrepresentation in certain situations. Misrepresentation or omissions on the application may result in termination or rescission of this Policy. This Policy may also be terminated if you knowingly participated in or permitted fraud or deception by any provider, vendor or any other person associated with this Policy. Termination for fraud or misrepresentation will be effective as of the Effective Date of coverage in the case of rescission.

4. For fraud or deception in the submission of claims or use of services or facilities or if you knowingly permit such fraud or deception by another. Termination is effective on the date of mailing the written notice.

5. Upon becoming enrolled under any other Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company non-group Policy.

Notice to Cancel or Cease Coverage and Our Right to Modify Your Policy

1. Before We will cease to provide any new or existing individual dental benefit Policy:
   a. We will give you at least 180 days written notice prior to cessation of this Policy, and
   b. Those individual dental benefit policies that are in effect shall not be canceled for 180 days, after the day of notification to cease coverage, except for specific non-compliance previously stated under the section **How Your Coverage Ends** in this PART.

2. We will give you ninety (90) days written notice before We withdraw this individual dental benefit Policy from the dental health care market.

3. In addition to the right to terminate, cancel or decline to renew the Policy set forth in **How Your Coverage Ends**, We have the right upon renewal, or at any time during the duration of your Policy to modify or otherwise change the terms and conditions of your Policy, **including premiums**, provided that We give you thirty (30) days written notice of such modifications or changes. Such modifications or changes may alter any term or benefit of this Policy, including without limitation, premiums, Covered Services, Deductibles and Covered Expense. We can modify or change the terms and conditions of your Policy at any time during the year on thirty (30) days written notice, regardless of whether your Deductible or other cost sharing provisions are calculated on an annual or calendar-Year basis.

In addition to the thirty (30) days written notice provision set forth above, our right to modify this Policy under the paragraph above is subject to the following conditions:

a. We will not cancel or modify this Policy under this paragraph 3. on an individual basis, but only for all covered persons enrolled in the same class that have the same coverage as you, except:

   (i) if We discover any fraud or intentional misrepresentation of material fact under the terms of the coverage by you.

   (ii) if We find out about any fraud or deception in the use of the benefits of this Policy by you or anyone else if you know about it.

b. The modifications or changes will take effect upon the next applicable renewal date occurring (determined as provided in paragraph a. above) on or after the 30th day following the date of the above notice.

4. If, on the date We cancel your coverage on written notice (except for the reasons described in this section under 1.a. and b.,3. or 4), you are suffering from either an injury sustained or an illness arising while your coverage under this Policy was in effect, benefits will continue, but limited by and subject to all of the following:

   a. These continued benefits cover only treatment of an injury sustained or an illness arising while your coverage under this Policy was in effect. When We refer to an injury sustained while your coverage under this Policy was in effect, We mean that the incident or accident directly causing the injury must have occurred while your coverage under this Policy was in effect. When We refer to an illness arising while your coverage under this Policy was in effect, We mean that either the illness was first diagnosed while your coverage under this Policy was in effect or your illness first manifested itself by signs or symptoms by which a Dentist could have diagnosed the illness while your coverage under this Policy was in effect.

   b. These benefits will be provided only for treatment actually received during the ninety (90) day period following cancellation of your coverage under this Policy.

   c. All conditions, reductions, limitations and exclusions of this Policy, including any benefit maximums, will apply to these continued benefits. In no event will benefits in excess of any Maximum Benefits be provided.

5. Any written notice will be officially given by us when it is mailed to your address as it appears on our records.

6. You should address any written notice to us at:

Anthem Blue Cross Life and Health Insurance Company
P.O. Box 9066
Oxnard, California 93031-9066

PART 3 WHAT IS COVERED

A. DEDUCTIBLE

Deductible is the amount of charges you will pay before We begin to pay for certain Covered Services.

1. Your yearly Deductible for Covered Services is $25.00. During each Year, you are responsible for all expense incurred up to the Deductible amount. Only Covered Expense counts toward the Deductible so amounts over Covered Expense a Non-Participating Dentist may charge you won't count.

2. If your yearly Deductible is not met in a given calendar Year, Covered Services incurred from October through December and applied toward the yearly Deductible for that calendar Year will also be applied to your yearly Deductible for the next calendar Year. If your yearly Deductible is satisfied in a given calendar Year, We will not carryover any amount applied toward that yearly Deductible to the next calendar Year's Deductible.

B. YEARLY MAXIMUM BENEFIT

All dental benefits are limited to a maximum payment of $1,000.00 for expense incurred by you during a Year.

C. BENEFIT WAITING PERIODS

You must be enrolled for 6 months under this Policy to be eligible for benefits for general (adjunctive) services.

You must be enrolled for 6 months under this Policy to be eligible for benefits for basic dental care.

You must be enrolled for 12 months under this Policy to be eligible for benefits for oral surgery services. This includes the excision of impacted teeth and simple extractions.

You must be enrolled for 12 months under this Policy to be eligible for benefits for endodontic services.

You must be enrolled for 12 months under this Policy to be eligible for benefits for periodontal services.

You must be enrolled for 12 months under this Policy to be eligible for benefits for prosthodontics.

D. PAYMENT

Payment is provided as follows for Covered Expense incurred. All payments are subject to any maximum amounts, limitations and exclusions as indicated in this Policy. If a Participating Dentist provides services, any billed amount above Covered Expense will be a savings to you. Participating Dentists have agreed to accept the Negotiated Fee Rate as payment in full. Non-Participating Dentists have no such policy with Anthem Blue Cross Life and Health, therefore, they will bill you for any amounts over Covered Expense in addition to any Deductible.

At a Participating Prudent Buyer Dentist benefits will be paid for Covered Expenses as follows:

- 100% of the Covered Expense you incur in excess of the Deductible for diagnostic and preventive services; (and
- 80% of the Covered Expense you incur in excess of the Deductible for general (adjunctive) services; and
- 80% of the Covered Expense you incur in excess of the Deductible for basic dental care services; and
- 50% of the Covered Expense you incur in excess of the Deductible for oral surgery services; and
- 50% of the Covered Expense you incur in excess of the Deductible for endodontic services; and
- 50% of the Covered Expense you incur in excess of the Deductible for periodontal services; and
- 50% of the Covered Expense you incur in excess of the Deductible for prosthodontics.

At a Non-Participating Dentist:

Benefits will be paid as indicated in the following Benefit Schedule **(after the Deductible has been satisfied)**. Please note, you may have a greater share of the costs if services are performed by a Non-Participating Dentist.

The Benefit Schedule below is a partial list of the Covered Services available to you. If the services you are receiving are not indicated in this schedule or if you need assistance in determining the maximum payable amount of any Covered Service, you may telephone us at the number shown on your identification (ID) card.

BENEFIT SCHEDULE

1. Diagnostic and Preventive Services

Procedure Code and Brief Description		At a Non-Participating Dentist, the Plan pays after Deductible
D1351	Sealants – per tooth limited to unrestored permanent 1st and 2nd molars (child up to the age of 16). Limited to one application per tooth and one replacement per tooth if replacement is performed at least 36 months after initial application……	$34
D1510	Space Maintainer-fixed-unilateral	$194
D1550	Recement space maintainers	$33

2. General (Adjunctive) Services

Procedure Code and Brief Description		At a Non- Participating Dentist, the Plan pays after Deductible
D9110	Palliative (emergency) treatment of dental pain (limited to once per Year)	$62
D9310	Consultation (diagnostic service provided by Dentist other than practitioner providing treatment) (limited to once per Year)	$74
D9430	Office visit for observation (during regularly scheduled hours) no other services performed (limited to once per Year)	$45

3. Basic Dental Care Services

Procedure Code and Brief Description		At a Non- Participating Dentist, the Plan pays after Deductible
D2951	Pin retention-per tooth	$38

4. Oral Surgery Services

Procedure Code and Brief Description		At a Non- Participating Dentist, the Plan pays after Deductible
D7140	Extraction – erupted tooth or exposed root	$98
D7210	Surgical removal of erupted tooth	$160
D7220	Removal of impacted tooth – soft tissue	$190
D7230	Removal of impacted tooth – partially bony	$239
D7240	Removal of impacted tooth – completely bony	$313
D9220	General anesthesia	$266

5. Endodontic Services

Procedure Code and Brief Description		At a Non- Participating Dentist, the Plan pays after Deductible
D3310	Anterior root canal (excluding final restoration)	$450
D3320	Bicuspid root canal (excluding final restoration)	$538
D3330	Molar root canal (excluding final restoration)	$663

6. Periodontal Services

Procedure Code and Brief Description		At a Non- Participating Dentist, the Plan pays after Deductible
D4210	Gingivectomy or gingivoplasty – 4 or more teeth per quadrant	$361
D4211	Gingivectomy or gingivoplasty – one to three teeth per quadrant	$177
D4341	Periodontal scaling and root planing, 4 or more teeth per quadrant	$152

7. Removable Prosthodontics

Procedure Code and Brief Description		At a Non- Participating Dentist, the Plan pays after Deductible
D5110	Complete denture – maxillary	$973
D5120	Complete denture – mandibular	$973
D5211	Maxillary partial denture – resin base	$749
D5212	Mandibular partial denture – resin base	$749
D5213	Maxillary partial denture – cast metal framework with resin denture bases	$1127
D5214	Mandibular partial denture – cast metal framework with resin denture bases	$1127
D5730	Reline complete maxillary denture (chairside)	$206
D5731	Reline complete mandibular denture (chairside)	$206
D5740	Reline maxillary partial denture (chairside)	$164
D5741	Reline mandibular partial denture (chairside)	$164
D5750	Reline complete maxillary denture (laboratory)	$264

D5751	Reline complete mandibular denture (laboratory)	$264
D5760	Reline maxillary partial denture (laboratory)	$250
D5761	Reline mandibular partial denture (laboratory)	$250

8. Fixed Prosthodontics

Procedure Code and Brief Description		At a Non- Participating Dentist, the Plan pays after Deductible
D2710	Crown – resin (laboratory) (single restoration)	$233
D2720	Crown – resin with high noble metal (single restoration)	$611
D2740	Crown – porcelain/ceramic substrate (single restoration)	$686
D2750	Crown – porcelain fused to high noble metal (single restoration)	$684
D2751	Crown – porcelain fused to predominantly base metal (single restoration)	$638
D2752	Crown – porcelain fused to noble metal (single restoration)	$667
D2780	Crown – ¾ cast high noble metal (single restoration)	$682
D2781	Crown – ¾ cast predominantly base metal (single restoration)	$638
D2782	Crown – ¾ cast noble metal (single restoration)	$665
D2783	Crown – ¾ porcelain/ceramic (single restoration)	$686
D2790	Crown – full cast high noble metal (single restoration)	$648
D2791	Crown – full cast predominantly base metal (single restoration)	$575
D2792	Crown – full cast noble metal (single restoration)	$602
D2930	Prefabricated stainless steel crown – primary tooth	$184
D6210	Pontic – cast high noble metal (fixed partial denture)	$648
D6211	Pontic – cast predominantly base metal (fixed partial denture)	$575
D6212	Pontic – cast noble metal (fixed partial denture)	$602
D6240	Pontic – porcelain fused to high noble metal (fixed partial denture)	$684
D6241	Pontic – porcelain fused to predominantly base metal (fixed partial denture)	$638
D6242	Pontic – porcelain fused to noble metal (fixed partial denture)	$667
D6245	Pontic – porcelain/ceramic (fixed partial denture)	$686
D6250	Pontic – resin with high noble metal (fixed partial denture)	$611
D6251	Pontic – resin with predominantly base metal (fixed partial denture)	$512
D6252	Pontic – resin with noble metal (fixed partial denture)	$565
D6720	Crown – resin with high noble metal (fixed partial denture)	$611
D6721	Crown – resin with predominantly base metal (fixed partial denture)	$512
D6722	Crown – resin with noble metal (fixed partial denture)	$565
D6740	Crown – porcelain/ceramic (fixed partial denture)	$686
D6750	Crown – porcelain fused to high noble metal (fixed partial denture)	$684
D6751	Crown – porcelain fused to predominantly base metal (fixed partial denture)	$638
D6752	Crown – porcelain fused to noble metal (fixed partial denture)	$667
D6780	Crown – ¾ cast high noble metal (fixed partial denture)	$682
D6781	Crown – ¾ cast predominantly base metal (fixed partial denture)	$638
D6782	Crown – ¾ cast noble metal (fixed partial denture)	$665
D6783	Crown – ¾ porcelain/ceramic (fixed partial denture)	$686
D6790	Crown – full cast high noble metal (fixed partial denture)	$648
D6791	Crown – full cast predominantly base metal (fixed partial denture)	$575
D6792	Crown – full cast noble metal (fixed partial denture)	$602

DENTAL CONDITIONS OF SERVICE

The following conditions of service must be met for expense incurred to be considered as Covered Services.

1. You must incur this expense while you are covered for dental benefits under this Policy. Expense is incurred on the date you receive the service or treatment for which the charge is made, except that for:
   a. Dentures and other similar Prosthetic devices: all expenses are incurred on the date the final impression is made.
   b. Fixed bridges, crowns, inlays, or onlays: all expenses are incurred on the date a tooth is first prepared.
   c. Root canal therapy: all expenses are incurred on the later of the dates that the pulp chamber is opened or a canal is explored to the apex.
   d. Periodontal surgery: all expenses are incurred on the date that the surgery is actually performed.
2. The service must be provided by a licensed provider and must be for preventive dental care or for treatment of dental disease, defect or injury.
3. The expense must be incurred for a dental service or treatment that is included under **What is Covered**.
4. The expense must not be for a dental service or treatment listed under **What is Not Covered**. If the service or treatment is partially excluded, then only that portion which is not excluded will be considered a Covered Service.
5. The expense must not exceed any dental benefit maximums, yearly Maximum Benefit, or limitations of this Policy.

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 terms, limitations and exclusions stated in this Policy, including the yearly Maximum Benefit and dental benefit maximums. The amount payable for Covered Services varies depending on whether you receive your care from a Participating Dentist or a Non-Participating Dentist.

BENEFITS WILL BE PROVIDED ONLY FOR THE SERVICES SPECIFIED IN THIS **COVERED SERVICES** SECTION. NO BENEFITS WILL BE PROVIDED FOR ANYTHING ELSE.

Diagnostic and Preventive Services

- **Sealants**, for unrestored permanent 1st and 2nd molars. Limited to one application per tooth and one replacement per tooth if replacement is performed at least 36 months after initial application. Covered only for children up to the age of 16.
- **Space Maintainers**. Limited to once per quadrant per lifetime for children up to the age of 16. Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes initial Prosthesis only and all adjustments within six months of placement.
- **Recement Space Maintainers**. Covered only after 12 months have passed since initial placement.

General (Adjunctive) Services

- **Palliative (Emergency) Treatment for Dental Pain**. Limited to one treatment per Year (not covered when performed in conjunction with other dental treatment or examination).

- **Consultations** (diagnostic service provided by a Dentist other than practitioner providing treatment). Limited to once per Year.

- **Office visit for observation**. Limited to one visit per Year. Not covered when associated with other services or procedures.

Basic Dental Care Services

For services to restore a tooth using a crown, see Prosthodontic Services. The following are covered basic dental care services under this Policy.

- **Pin retention**. Limited to once per tooth in any 12 month period (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.

Oral Surgery Services

For surgical procedures related to the gums and to the bone that supports teeth, see Periodontal Services. Covered oral surgery includes:

- **Extraction of coronal remnants, primary tooth**
- **Extraction, erupted tooth or exposed root**
- **Surgical removal of erupted tooth**
- **Removal of impacted tooth, soft tissue, partially bony, and completely bony**
- **Surgical removal of residual tooth roots**
- **Oral antral fistula closure**
- **Primary closure of sinus perforation**
- **Removal of lateral exostosis**
- **Removal of torus, palatinus and mandibularis**
- **Surgical reduction of osseous tuberosity**
- **Alveoloplasty**
- **Vestibuloplasty**
- **Biopsy of oral tissue, hard and soft**
- **Frenulectomy, frenuloplasty**
- **Excision of hyperplastic tissue**
- **Excision of pericoronal gingiva**
- **Surgical incision and drainage**
- **General anesthesia and intravenous (IV) sedation,** when used in conjunction with covered oral surgical procedures if Medically Necessary.

Endodontic Services

- **Root Canal Therapy**. Coverage for root canal therapy includes a Treatment Plan, clinical procedures, postoperative radiographs, and follow-up care. If multiple endodontic treatments are necessary on the same tooth within a period of one year, the allowance will be made for only one procedure. Root canal therapy is limited to one initial treatment per tooth per lifetime and one retreatment per tooth per lifetime. Coverage is for permanent teeth only.

The following endodontic services are limited to a lifetime maximum of once per tooth/root:

- **Apicoectomy/periradicular services**. The allowable charge for apicoectomy/periradicular services includes reimbursement for the removal of granulation tissue at the apex of the tooth. No additional benefit is available for the removal of granulation tissue at the apex of the tooth if billed separately from the apicoectomy/periadicular service. Limited to once per tooth per lifetime.
- **Retrograde filling**. Limited to once per root per lifetime.
- **Therapeutic pulpotomy (excluding final restoration)**. Coverage is for primary teeth only. Limited to once per tooth per lifetime.
- **Pulp capping, direct and indirect**. Coverage is for permanent teeth only. Limited to once per tooth per lifetime.
- **Gross pulpal debridement**. Not payable if performed in conjunction with root canal treatment or palliative emergency treatment. Limited to once per tooth per lifetime.

Periodontal Services

Coverage for periodontal surgical services includes Treatment Plan, local anesthesia, and routine postoperative care. Covered periodontal surgical services are:

- **Gingivectomy or gingivoplasty**. Limited to once per quadrant in any three years. 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)**. Limited to once per quadrant in any three years.
- **Apically positioned flap**. Limited to once per quadrant in any three years.
- **Crown lengthening**. Limited to once per tooth per lifetime.
- **Osseous surgery, including flap entry with closure**. Limited to once per quadrant in any three years.
- **Bone replacement grafts** are a Covered Service for replacement of bone loss due to periodontal disease or defects only. No benefit is available for bone replacement grafts done in conjunction with extraction sites, ridge augmentation, or in preparation for the placement of implants.
- **Soft tissue grafts**. The allowable charge for a soft tissue graft includes removal of tissue from a donor site and a single graft for one tooth or a single graft covering two adjacent teeth. No additional benefit is available when removal of the donor tissue is billed separately from the soft tissue graft or a single graft for two adjacent teeth is billed separately. Grafts are covered only to treat periodontal disease or defects.
- **Guided tissue regeneration**. Limited to once per tooth/site per lifetime.
- **Biologic materials to aid in soft and osseous tissue regeneration**. Limited to once per tooth/site per lifetime.

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 once per lifetime.
- **Periodontal scaling and root planing**. Limited to once per quadrant every 24 months.
- **Periodontal maintenance procedure**. Covered only when following active periodontal therapy. Limited to two procedures per Year.

Prosthodontics (Crowns, Inlays, Onlays)

- **Crowns, Inlays, Onlays**. Benefits for crowns, inlays, and onlays are limited to once per tooth in any seven years, whether or not placement was under this Policy, even if the original crown was stainless steel or “temporary”. Laboratory-fabricated restorations and crowns are covered only when the tooth cannot be restored with routine filling material.
- **Recementing of crowns/inlays/onlays**. Limited to a lifetime maximum of once per crown/inlay/onlay.
- **Crown buildups (includes pins)**. Limited to once per tooth in any seven year period (whether or not placement was under this Policy). Amalgam and/or composite restorations submitted in conjunction with crown buildups or post and core procedures will be considered as part of those procedures. Crown buildups performed in conjunction with post and core procedures will be considered part of those procedures. Crown buildups on the same tooth as an amalgam or composite restoration done within the same Year will not be covered.
- **Post and core buildups**. Limited to once per tooth in any seven year period, after root canal therapy.
- **Crown/onlay repairs**. Limited to once per crown/onlay in any seven year period.
- **Stainless steel crowns (for primary teeth only)**. Benefits are not provided for stainless steel crowns when used as a temporary crown.
- **Recement cast or prefabricated post and core**. Limited to once per tooth per lifetime.

Prosthodontics, Removable

The allowable charge for these services includes routine post-delivery care and all adjustments within the first 6 months after initial placement. Services are covered for Policyholder age 16 and over.

Covered Services include:

- **Removable complete (immediate or permanent)**, **and partial dentures**, but only if the tooth/teeth being replaced were extracted after the Policyholder’s Effective Date. Limited to once in seven years. Benefits are available for the replacement of complete or partial dentures, but only if the Prosthesis is seven years old or older and cannot be made serviceable. Benefits are payable for either complete or immediate dentures, but not both.
- **Denture adjustments**. Limited to once per Year per denture.
- **Denture repairs**. Limited to once per denture in a seven year period.
- **Addition of tooth or clasp**. Limited to a lifetime maximum of one tooth addition and 2 clasp additions per denture.
- **Replace all teeth and acrylic on partial denture**. Limited to once per arch in any seven year period.
- **Denture rebase and reline procedures**. Limited to once per Year for chairside reline and once in three years for laboratory rebase or reline.
- **Tissue conditioning**. Limited to 2 treatments per arch in any 12-month period.

Note: Adjustments, repairs or relines to dentures are not covered for a period of six months from initial placement if the denture(s) were paid for under this Policy.

Prosthodontics, Fixed

Fixed Prosthodontics are not a Covered Service when all molars are missing on one or both sides of an arch. Benefits are provided for the replacement of an existing bridge if it is seven years old or older and cannot be made serviceable.

- **Fixed Bridges** are covered only when:
  1. The bridge is replacing teeth that were extracted after the Policyholder's Effective Date; and
  2. The total units required to replace all missing teeth is six units or less in an arch (arch means maxilla or mandible); and
  3. The bridge or bridges consist of no more than 6 units total in an arch. (Each abutment is a unit and each pontic is a unit in a bridge). The allowable charge for fixed bridgework that includes more than a total of 6 units is limited to the amount this Policy would pay for a removable partial denture.
- **Recementing a bridge**. Limited to a lifetime maximum of once per bridge.
- **Post and core**. Limited to once per tooth in a seven year period, after root canal therapy.
- **Core buildup**. Limited to once per tooth in a seven year period.
- **Bridge repair**. Limited to once per bridge in a seven year period.

Note: Benefits will not be provided for a pontic or an abutment if a fixed or removable partial, crown, or onlay was placed on the affected tooth/teeth in the last seven years.

PART 4 WHAT IS NOT COVERED

This section indicates items which are excluded and are not considered Covered Services. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services. This list of exclusions is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services. We are the final authority for determining if services or treatments are Covered Services. We do not provide benefits for:

A. **Unlisted Services**: Services not included as a covered procedure under the Covered Services section of this Policy.

B. **Excess Amounts**: Any amounts in excess of the maximum amounts stated in the PART called “WHAT IS COVERED”.

C. Any amounts which exceed the **Covered Expense** as determined by Anthem Blue Cross Life and Health Insurance Company.

D. **Expenses Before Coverage Begins**: Services received before your Effective Date or during an inpatient stay that began before your Effective Date.

E. **End of Coverage**: Services received after your coverage ends.

F. **Services For Which You Are Not Legally Obligated To Pay**: Services for which no charge is made to you in the absence of insurance coverage.

G. **Services for someone other than the Policyholder**: Any person other than the Policyholder, including but not limited to the Policyholder’s dependents such as spouse, domestic partner, newborn, legal ward, natural and/or adopted child.

H. **Workers’ Compensation**: Any condition for which benefits are recovered or can be recovered, either by any workers’ compensation law or similar law even if you do not claim those benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to worker’s compensation law or similar law, We will provide the benefits of this plan for such conditions, subject to the right to a lien or other recovery under section 4903 of the California Labor Code or other applicable law.

I. **Governmental Service**: Any services provided by a local, state, county or federal government agency including any foreign government.

J. **Services From Relatives**: Professional services received from a person who lives in your home or who is related to you by blood, marriage or adoption.

K. **Cosmetic Dentistry**: Any services performed for cosmetic purposes (including but not limited to external bleaching, bleaching of non-vital discolored teeth, composite restorations, veneers, crowns on teeth not exhibiting pathology and facings on crowns on posterior teeth).

L. **Charges for treatment by other than a licensed Dentist**.

M. **Orthodontic services**, cephalometric film, tomographic survey, braces, appliances and all related services.

N. Any services related to diagnosis or treatment by any method of any condition related to the jaw joint **(temporomandibular joint or TMJ)** or associated musculature, nerves and other tissues, regardless of the reason(s) such services are necessary.

O. **Procedures requiring appliances or restorations** (other than those for replacement of structure loss due to tooth decay) that are necessary to alter, restore or maintain occlusions. These include but are not limited to:

1. Changing the vertical dimension.
2. Replacing or stabilizing lost tooth structure by attrition, abrasion, abfraction, erosion or bruxism.
3. Realignment of teeth.
4. Gnathological recording.
5. Occlusal equilibration.
6. Periodontal splinting.

P. **Oral examinations** including: periodic, limited, comprehensive, detailed and extensive oral evaluations, re-evaluations, and comprehensive periodontal evaluations**.**

Q. **Prophylaxis** (teeth cleaning).

R. **Radiographs including**: intraoral, intraoral complete series, intraoral occlusal, extraoral, periapical, bitewings, vertical bitewings, posterior-anterior or lateral skull and facial bone survey film, oral facial photographs, and panoramic films.

S. **Fluoride applications**.

T. **Correction of congenital or development malformation** including but not limited to supernumery and/or over retained deciduous teeth, cleft palate, maxillary or mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).

U. **Fillings:** Amalgam and resin based composite restorations.

V. **Transfer of care**: If a Policyholder transfers from the care of one Dentist to that of another Dentist during the course of treatment, or if more than one Dentist renders services for one dental procedure, We shall be liable only for the amount We would have been liable for had one Dentist rendered the services.

W. **Any prescribed drugs, pre-medication or analgesia (including charges for nitrous oxide) or any similar local anesthetic when the charge is made separately from a Covered Service.**

X. **Charges for tobacco counseling, oral hygiene instruction, dietary planning, or behavior management.**

Y. **Malignancies and Neoplasms**: Services for treatment of malignancies and neoplasms are not Covered Services.

Z. **All hospital costs and any additional fees charged by the Dentist for hospital treatment**.

AA. **Implants**: Materials implanted into or on bone or soft tissue and all adjunctive services (including but not limited to surgery, prosthetics placed on implants, cleanings, maintenance, etc.) performed in conjunction with the placement or removal of implants.

BB. **Services, treatments or Supplies That Are Not Medically Necessary**.

CC. **Experimental/Investigational**. Services or supplies which are Experimental/Investigational or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigational service or supply.

DD. Services within the first 12 months of the Policyholder's Effective Date for:

- oral surgery services
- endodontic services
- periodontal services
- prosthodontics.

EE. Services within the first 6 months of the Policyholder's Effective Date for:

- general (adjunctive) services
- basic dental care services.

FF. Claims received after 12 months from the date service was rendered.

GG. Procedures not yet recognized by the American Dental Association as indicated with a specific procedure code designation, or procedures which are considered experimental or investigative in nature or which are not widely accepted as proven and effective procedures within the organized dental community.

HH. Any services for treatment of illness or injury that occurs as a result of any act of war, declared or undeclared.

II. Any services 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 felony (unless otherwise required by law). Services, treatments 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.

JJ. Any amounts in excess of the dental benefit maximums and yearly Maximum Benefit stated in this Policy. The Covered Expense for all Covered Services includes the administration of any local anesthesia and the provision of infection control procedures as required by state and federal mandates. If billed separately, such charges will be denied.

KK. Harmful Habit Appliances: Fixed and removable appliances to inhibit thumbsucking, athletic mouthguards.

LL. Replacement of an existing fixed or removable Prosthesis for which benefits were paid if replacement occurs within seven years of the original placement.

MM. Replacement of crowns, inlays, onlays and laboratory-fabricated restorations if replacement occurs within seven years of the original placement.

NN. Lost or Stolen Dentures or Appliances. Replacement of existing full or partial dentures or Appliances which have been lost or stolen.

OO. Charges for any duplicate Prosthetic device or Appliance, or for a "spare" set of dentures or any other duplicate Appliance such as, but not limited to, removable orthodontic retainers.

PP. Placement of or replacement of existing restorations for any purpose other than the treatment of pathology or decay.

QQ. The extraction of immature erupting third molars and nonpathologic, asymptomatic third molars is excluded. Third molar extractions are not covered for children under age 16.

RR. Histopathological exams (examination of cells by microscope) and/or the removal of tumors, cysts, and foreign bodies.

SS. 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
- Retrograde filling
- Root canal therapy

TT. Personalization or characterization of dentures or teeth. Precision attachments and the replacement of part of a precision attachment.

UU. Overdentures and related services, including root canal therapy on teeth supporting an overdenture.

VV. Maxillofacial Prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation.

WW. Prosthetics for patients under sixteen years of age including but not limited to fixed bridges, dentures, removable partials, crowns, inlays and onlays.

XX. Temporary and interim Prosthetics (temporary crowns, bridges, partials, dentures, etc.). Temporary services are considered an integral part of the final services rather than a separate service, and are therefore not eligible for benefits.

YY. Occlusal guards, occlusal adjustments (complete or limited) and occlusal analysis.

ZZ. Professional visits for house/extended care facility, hospital calls, office visits after regularly scheduled hours, and case presentations.

AAA. Teeth lost prior to coverage under this Policy are not eligible for Prosthetic replacement unless the Prosthetic replacement replaces one or more eligible natural teeth lost during the term of this coverage.

BBB. If more than one Treatment Plan would be considered Medically Necessary for a dental condition, any amount exceeding the cost of the least expensive professionally acceptable Treatment Plan is not covered.

CCC. Charges for missed or cancelled appointments.

PART 5 IMPORTANT INFORMATION ABOUT YOUR PLAN

WORKERS' COMPENSATION INSURANCE: This Policy does not take the place of or affect any requirement for or coverage by, workers' compensation insurance.

BENEFITS NOT TRANSFERABLE: You are the only person entitled to receive benefits under this Policy. FRAUDULENT USE OF SUCH BENEFITS WILL RESULT IN CANCELLATION OF THIS POLICY AND APPROPRIATE LEGAL ACTION WILL BE TAKEN.

Conformity of this Policy
Any provision of this Policy which, on its Effective Date, is in conflict with any applicable statute, regulations or other law is hereby amended to conform to the minimum requirements of such law.

Content of this Policy
This Policy, including any endorsements or attached paper, is the entire contract of insurance. Its terms can be changed only by a written endorsement signed by one of our authorized officers. NO AGENT OR EMPLOYEE OF OURS IS AUTHORIZED TO CHANGE THE TERMS OR WAIVE ANY OF THE PROVISIONS OF THIS POLICY.

RELATIONSHIP OF PARTIES: We are not responsible for any claim for damages or injuries suffered by you while receiving care in any hospital, skilled nursing facility, or Dentist's office. Such facilities act as independent contractors.

RESPONSIBILITY TO PAY PROVIDERS: You will not be required to pay any Participating Dentist for amounts owed to that provider by us (not including your portion of Covered Expenses, Deductibles and services or supplies that are not a benefit of this Policy), even in the unlikely event that We fail to pay the provider. You are liable, however, to pay Non-Participating Dentists for any amounts not paid to them by us.

SUBMISSION OF CLAIMS: Either the Policyholder or provider of service must claim benefits by sending us properly completed claim forms itemizing the services or supplies received and the charges. These claim forms must be received by us within 15 months of the date services or supplies are received. We will not be liable for the benefits if a completed claim form is not furnished to us within this time period. Claim forms must be used; cancelled checks or receipts are not acceptable.

RIGHT OF RECOVERY: When the amount paid by us exceeds the amount for which We are liable under this Policy, We have the right to recover the excess amount from you unless prohibited by law.

TERMS OF COVERAGE:

- In order for you to be entitled to benefits under this Policy your coverage under this Policy must be in effect on the date expense giving rise to a claim for benefits is incurred, except as specifically provided under the PART called "WHAT YOU SHOULD KNOW ABOUT YOUR COVERAGE". Under this Policy, an expense is incurred on the date you receive a service or supply for which the charge is made.

- This Policy, including all terms, benefits, conditions, limitations and exclusions may be changed by us as provided in the PART called "WHAT YOU SHOULD KNOW ABOUT YOUR COVERAGE".

- The benefit to which you may be entitled will depend on the terms of coverage as set out in the Policy in effect on the date you receive the service or supply.

Receipt of Information: We are entitled to receive from any provider of service information about you that is necessary to administer claims on your behalf. This right is subject to all applicable confidentiality requirements. By submitting an application for coverage, you have authorized every provider who has furnished or is furnishing care to disclose all facts, opinions or other information pertaining to your care, treatment and physical conditions, upon our request. You agree to assist in obtaining this information if needed. Failure to assist us in obtaining the necessary information when requested may result in the delay or rejection of your claims until the necessary information is received.

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. Contact us toll free at (888) 209-7852 for a copy.

CONTENT OF THE POLICY: This Policy, including any endorsements or attached paper, is the entire contract of insurance. Its terms can only be changed by a written endorsement signed by one of our authorized officers. NO AGENT OR EMPLOYEE OF OURS HAS ANY AUTHORITY TO CHANGE THE TERMS, OR WAIVE ANY OF THE PROVISIONS, OF THIS POLICY.

TIME LIMIT ON CERTAIN DEFENSES: After you have been insured under this Policy for two (2) consecutive years, We will not use any misstatements you may have made in your application for this Policy, except any fraudulent misstatements, to either void this Policy or to deny a claim for any Covered Expense for Covered Services incurred after the expiration of such two (2) year period.

TIME OF PAYMENT OF CLAIM: Any benefits due under this Policy shall be due once We receive proper, written proof of loss together with any such additional information reasonably necessary to determine our obligation.

LEGAL ACTIONS: No action at law or at equity may be brought to recover on this Policy sooner than sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action may be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

GOVERNING LAW: The laws of the State of California will be used to interpret any part of this Policy.

REINSTATEMENT: If this Policy lapses (cancels) because you don’t pay your premium on time and if We, or an agent We’ve authorized to accept premium, then accepts a late premium payment from you without asking for an application for reinstatement, We will reinstate this Policy. However, if We require an application for reinstatement and give you a conditional receipt for your late premium payment, We will only reinstate this Policy if either We approve your reinstatement application or 45 days go by after the date on our conditional receipt without us notifying you in writing that We’ve disapproved your reinstatement application.

If this Policy is reinstated, benefits will be provided only for an Accidental Injury that occurs after the date of reinstatement or for a dental condition that begins more than 10 days after the date of reinstatement. Otherwise, your rights and our rights under this Policy will be the same as they were just before the premium you didn’t pay on time was due, unless We amended this Policy in connection with reinstatement. Any premium We accept in connection with reinstatement will be applied to a period for which you haven’t paid premium due, but not to any period more than 60 days before the date of reinstatement.

Anthem Blue Cross Life and Health shall neither increase the premiums payable by you, nor decrease in any manner the benefits and coverages provided hereunder, except after at least thirty (30) days prior written notice to you.

CONTINUATION OF CARE AFTER TERMINATION OF A PARTICIPATING DENTIST: Upon the termination of the contract or other agreement with any Participating Dentist, We shall be liable to pay the cost of Covered Services (other than applicable co-payments) rendered by that Participating Dentist to the Policyholder who retains eligibility under this Policy or by operation of law, and who is under the care of that Participating Dentist at the time of such termination, and that Participating Dentist shall continue to provide such services to you in accordance with the terms of this Policy, until the services being rendered are completed, unless reasonable and medically appropriate provision is made for the assumption of such services by another Participating Dentist.

Payment to Providers and Provider Reimbursement: Covered Expenses for Participating Dentists are based on the Negotiated Fee Rate. Participating Dentists have a Participating Dentist Agreement in effect with us and have agreed to accept the Negotiated Fee Rate as payment in full. Non-Participating Dentists do not have a Participating Dentist Agreement with Anthem Blue Cross Life and Health Insurance Company. Your personal financial costs when using Non-Participating Dentists may be considerably higher than when you use Participating Dentists. You will be responsible for any balance of a Dentist's bill which is above the Covered Expense payable under this Policy for Non-Participating Dentists, in addition to any Deductible. Please read the benefit sections carefully to determine those differences. We pay the benefits of this Policy directly to Participating Dentists and other participating providers, whether you have authorized assignment of benefits or not. We may pay Non-Participating Dentists and other providers of service, or the person or persons having paid for your dental services directly when you assign benefits in writing no later than the time of filing proof of loss (claim). These payments fulfill our obligation to you for those services.

CONTRACTING ENTITY: You hereby expressly acknowledge that you understand that this Policy constitutes a contract solely between you and Anthem Blue Cross Life and Health Insurance Company, which is an independent corporation operating under a license from the Blue Cross Association, an association of independent Blue Cross Plans, permitting Anthem Blue Cross Life and Health Insurance Company to use the Blue Cross Service Mark in the State of California, and in doing so, Anthem Blue Cross Life and Health Insurance Company is not contracting as the agent of the Blue Cross Association. You further acknowledge and agree that you have not entered into this Policy based upon representations by any person other than Anthem Blue Cross Life and Health Insurance Company and that no person, entity or organization other than Anthem Blue Cross Life and Health Insurance Company shall be held accountable or liable to you for any of our obligations created under this Policy. This paragraph shall not create any additional obligations whatsoever on the part of Anthem Blue Cross Life and Health Insurance Company other than those obligations created under other provisions of this Policy.

PART 6 DENTAL UTILIZATION REVIEW

Dental Utilization Review

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

Dental utilization review is accomplished through pre-treatment review and retrospective review. Our dental coverage guidelines for pre-treatment review and retrospective review are intended to reflect the standards of care for dental practice and state-specific regulations. The purpose of dental coverage guidelines is to assist in the interpretation of Medical Necessity. In order to be Covered Expenses or services under this Policy, expenses must meet the Medically Necessary requirements.

Pre-Treatment Review

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

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

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

Retrospective Review

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

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

If a Policyholder disagrees with a utilization review decision and wishes to file a grievance, or appeal a decision previously made you will find details on how to do this in the grievance and appeals section of this Policy. You may also contact our customer service number on your identification (ID) card. The utilization review process is governed by laws and regulations, and may be modified from time to time by us as those laws and regulations may require.

PART 7 IF YOU HAVE A COMPLAINT

COMPLAINTS

If you have a complaint about services from Anthem Blue Cross Life and Health or your health care provider, please call us first toll free at (888) 209-7852 or write to us at:

Anthem Blue Cross Life and Health Insurance Company
P.O. Box 9066
Oxnard, California 93031-9066

If you have any questions regarding your eligibility or membership, please contact us toll free at (866) 333-4820, or you may write to us at:

Anthem Blue Cross Life and Health Insurance Company
P.O. Box 9051
Oxnard, California 93031-9051

DEPARTMENT OF INSURANCE

If you have a problem regarding your coverage, please contact us first to resolve the issue. If contacts between you (the complainant) and Anthem Blue Cross Life and Health Insurance Company (the Insurer) have failed to produce a satisfactory solution to the problem, you may wish to contact the Department of Insurance. They can be reached by writing to:

Department of Insurance, Consumer Affairs Bureau
300 South Spring St. South Tower
Los Angeles, California 90013
Toll free phone number 1-800-927-HELP (4357)

BINDING ARBITRATION

Any dispute or claim arising out of this Policy or breach thereof, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court.

Any disputes regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Policyholder and Anthem Blue Cross Life and Health agree to be bound by the arbitration provision and acknowledge that they are giving up their right to a trial by court or jury.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this BINDING ARBITRATION provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate shall apply. With respect to an arbitration held in California, should the Federal Arbitration Act not apply, the California Arbitration Act, Code of Civil Procedure Sections 1280. et seq.shall apply.

The arbitration is initiated by you making written demand on Anthem Blue Cross Life and Health. The arbitration will be conducted by the Judicial Arbitration and Mediation Services ("JAMS"), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Policyholder and Anthem Blue Cross Life and Health, or by order of the court, if you and Anthem Blue Cross Life and Health cannot agree.

The costs of this arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to whom the parties have agreed, in which cases, We will assume all or a portion of the costs of the arbitration.

Should damages claimed be $50,000.00 or less, the arbitration shall be held by a single neutral arbitrator mutually agreed to by the parties. Such arbitrator shall have no jurisdiction to award more than $50,000.00. The arbitrator shall be selected in accordance with the applicable rules of the arbitration administration entity. With respect to an arbitration held in California, if the parties are unable to agree on the selection of an arbitrator using the rules of the arbitration administration entity, the method provide in Code of Civil Procedure Section 1281.6 shall be used.

You and Anthem Blue Cross Life and Health agree to give up the right to participate in class arbitrations against each other. Even if applicable law permits class actions or class arbitrations you waive any right to pursue, on a class basis, any such controversy or claim against Anthem Blue Cross Life and Health and Anthem Blue Cross Life and Health waives any right to pursue on a class basis any such controversy or claim against you.

The arbitration findings will be final and binding except to the extent that California or federal law provides for the judicial review of arbitration proceedings.

Please send all Binding Arbitration demands in writing to: Anthem Blue Cross Life and Health Insurance Company, P.O. Box 9066, Oxnard, California, 93031-9066.

PART 8 NON-DUPLICATION OF ANTHEM BLUE CROSS LIFE AND HEALTH BENEFITS

If, while covered under this individual Policy, you are also covered by another Anthem Blue Cross Life and Health Insurance Company individual policy:

- You will be entitled only to the benefits of the policy with the greater benefits, and
- We will refund any premiums received under the policy with the lesser benefits, covering the time period both policies were in effect. However, any claims payments made by us under the policy with the lesser benefits will be deducted from any such refund of premiums.

PART 9 IMPORTANT TERMS TO KNOW

Listed below are the definitions of important terms in this Policy which appear with the first letter of each word in capital letters. When you see these capitalized words, you should refer to these definitions, which are listed in alphabetical order.

A. **Accidental Injury** is physical harm or disability which is the result of a specific, unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental Injury does not include illness or infection, except infection of a cut or wound. Damage to teeth due to chewing or biting is not an Accidental Injury.

B. The **Benefit Schedule** is the list of the maximum amounts payable by us to Non-Participating Dentists for Covered Services. The Benefit Schedule amounts are subject to applicable Deductibles and other benefit limitations.

C. **Benefit Waiting Period** – the period of continuous coverage under this Policy that you must complete following your Effective Date before dental benefits are payable for Covered Services. No payment will be made for expenses incurred during the Benefit Waiting Periods indicated in the PART called WHAT IS COVERED.

D. **Anthem Blue Cross Life and Health Insurance Company ("Anthem Blue Cross Life and Health" "Anthem")** is a life and disability insurance company regulated by the California Department of Insurance.

E. **Covered Expense** is the expense you incur for Covered Services. For a Participating Dentist, the Covered Expense is the Negotiated Fee Rate. For a Non-Participating Dentist, the Covered Expense is the lesser of the Dentist's actual charge or our then effective Benefit Schedule. The Benefit Schedule may be subject to periodic review and modification. Covered Expense is incurred on the date the Policyholder receives the service or supply for which the charge is made.

F. **Covered Services** are Medically Necessary services or supplies which are listed in the benefit sections of this Policy, and for which you are, in accordance with the terms, conditions, limitations and exclusion of this Policy, entitled to receive benefits.

G. **Deductible** means the amount of charges you must pay in a calendar Year for any Covered Services before certain benefits are available to you under this Policy. Your Deductible is explained in the PART of this Policy called "WHAT IS COVERED".

H. **Dentist** is one who is licensed to practice dentistry by the governmental authority having jurisdiction over the licensure and practice of dentistry.

I. The **Effective Date** is the date your coverage under this Policy begins. It appears on your identification card.

J. The **Maximum Benefit** is the maximum amount of benefits available to you during a Year. All benefits furnished are subject to this maximum amount. This amount is stated in the PART called "WHAT IS COVERED" under yearly Maximum Benefit.

K. **Medically Necessary (Medical Necessity)** shall mean health care services that a Dentist exercising professional clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating a dental injury or dental condition or its symptoms, and that are:

- In accordance with generally accepted standards of dental practice within the organized dental community
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient with the particular dental condition being treated than other possible alternatives
- Not primarily for the convenience of the patient, or Dentist or other provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's dental needs.

For these purposes "generally accepted standards of dental practice" means standards that are based on credible scientific evidence published in peer-reviewed dental literature generally recognized by the relevant dental community, specialty society recommendations, and the views of Dentists practicing in relevant clinical areas and any other relevant factors.

L. **Negotiated Fee Rate** is the rate of payment that Anthem Blue Cross Life and Health Insurance Company has negotiated with participating providers under a Prudent Buyer Participating Provider Agreement for Covered Services furnished to you.

M. **Non-Participating Dentist** is a Dentist who does not have a Prudent Buyer Participating Dentist Agreement in effect with Anthem Blue Cross Life and Health at the time services are rendered.

N. **Participating Dentist** is a Dentist who has a Prudent Buyer Plan Participating Dentist Agreement in effect with us at the time services are rendered. Participating Dentists have negotiated certain charges as the Negotiated Fee Rate they will charge you for Covered Services. A list of Participating Dentists is available upon request.

O. **Policy** is the set of benefits, conditions, exclusions and limitations described in this document.

P. **Policyholder** is the person whose enrollment application has been accepted by us for coverage under this Policy.

Q. **Prosthesis (Prosthetics)** - A restorative service used to replace one or more missing or broken teeth and associated tooth structures. It includes all types of crowns, pontics, inlays, onlays, bridges, and dentures.

R. **Treatment Plan** - A detailed description, submitted by the provider, outlining the proposed services and fees including any appropriate radiographs and diagnostic information.

S. **We** (us, our) refers to Anthem Blue Cross Life and Health Insurance Company.

T. **A Year** is a 12-month period starting January 1 at 12:01 a.m. Pacific Standard Time.