Anthem

Anthem Blue Cross and Blue Shield
INDIVIDUAL TONIK SM PPO DENTAL
X425

NOTE: COVERAGE UNDER THIS POLICY IS LIMITED TO SPECIFIED DIAGNOSTIC AND PREVENTIVE SERVICES AND FILLINGS. NO BENEFITS ARE PROVIDED FOR OTHER SERVICES.

If you have any questions regarding your eligibility or membership please feel free to contact us toll free at (800) 317-9818 or you may write to us at Anthem Blue Cross and Blue Shield, P.O. Box 5728, Denver, CO 80217-5728.

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 and Blue Shield, P.O. Box 9274, Oxnard, CA 93031-9274.

Thank you for choosing Anthem Blue Cross and Blue Shield.

David S. Helwig
President and CEO
Anthem Blue Cross and Blue Shield

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X425

INDIVIDUAL TONIK PPO DENTAL

ISSUED BY

Anthem Blue Cross and Blue Shield (Anthem)

NOTE: COVERAGE UNDER THIS POLICY IS LIMITED TO SPECIFIED DIAGNOSTIC AND PREVENTIVE SERVICES AND FILLINGS. NO BENEFITS ARE PROVIDED FOR OTHER SERVICES.

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 privacy rights. You can get a copy by checking our website at **tonikhealth.com** or by calling us at (888) 209-7852.

Your dental coverage is defined in the following documents:

- This Policy and any amendments or endorsements thereto.
- Your individual enrollment application/change form
- Your identification card
- Your individual rate sheet

Dentists and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. A Network Dentist may, after notice from Anthem, be subject to a reduced Maximum Allowable Amount in the event the Network Dentist fails to make routine referrals to In-Network providers except as otherwise allowed (for example for emergency services). Health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis. For additional information you may contact our dental customer service department toll free at (888) 209-7852 or your Network Dentist.

Anthem Blue Cross and Blue Shield (Anthem) 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 and Blue Shield (Anthem)**. "You," "your" and "Policyholder" means the eligible Policyholder whose individual 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.

Questions? Visit our web site **tonikhealth.com** or call customer service **1-800-317-9818**

Note: This Policy covers the named Policyholder only and does not provide benefits for dependents, such as a spouse, domestic partner, legal ward, natural child, adopted child and/or newborn child (except for the first 31 days after birth, adoption or placement for adoption) as described in the PART called WHAT YOU SHOULD KNOW ABOUT YOUR COVERAGE. 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 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. **Please be aware than an application for coverage does not guarantee coverage; all applications are subject to medical underwriting.**

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 SERVICE. 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 Colorado. Any benefits received for services performed out of the State of Colorado may be significantly lower and result in a greater out-of-pocket expense for you.

Anthem, or anyone acting on our behalf, will generally determine how benefits will be administered and who is eligible for participation in a manner that is consistent with the terms of this Policy. In the event of any question as to the interpretation of any provision of this Policy, Anthem's determination will be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental/Investigational, or, in the case of surgery, cosmetic. However, you may utilize all applicable complaint, grievance and appeal procedures available under this Policy.

THE ENTIRE POLICY SETS FORTH, IN DETAIL, THE RIGHTS AND OBLIGATIONS OF BOTH YOU AND Anthem. 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.

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 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 receive 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 except for newborn children, adopted children and children placed for adoption as described under the PART called WHAT YOU SHOULD KNOW ABOUT YOUR COVERAGE. If you let someone else use your ID card, your coverage could be terminated even back to its original Effective Date.

Choosing Dentists

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

Benefits are available In-Network

This Anthem Preferred Provider Organization (PPO) Plan gives you access to care through a network of Dentists. These In-Network Dentists are called Network Dentists. They contract with us to provide services to you at pre-negotiated discounted rates (called the Maximum Allowable Amount). Covered Services for Network Dentists are based on the Maximum Allowable Amount. Network Dentists have a Network Dentist Participating Agreement in effect with us and have agreed to accept the Maximum Allowable Amount as payment in full. Using Network Dentists helps provide maximum savings for you. In addition, Network Dentists will file your claims with us. For a directory of Network 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-Network Dentists) and receive benefits for Covered Services. However, Non-Network Dentists do not have a 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 (Maximum Allowable Amount) for Non-Network Dentists. In addition to any deductible, you will be responsible for any balance of a Dentist's bill which is above the allowed amount (Maximum Allowable Amount) payable under this Policy for Non-Network 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-Network 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 your ID number on the card. If you're going to be late or you can't go to your appointment, be sure to 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. This charge is not reimbursable by us.

How To Submit a Claim

Network Dentists will submit your claims to us. However, if you go to a Non-Network Dentist either you or the Dentist must claim benefits by sending Anthem properly completed claim forms itemizing the services or supplies received and the charges. Claim forms that you or a Non-Network Dentist submits must be received by Anthem within three hundred sixty five (365) days from the date the services or supplies are received. Anthem will not be liable for benefits if a completed claim form is not furnished to Anthem within this time period, unless it is shown that it was not reasonably possible to file a claim within this time period and that the claim was filed as soon as reasonably possible. If We fail to provide you a claim form within fifteen (15) days of your request, you will be deemed to having complied with the requirements of this Policy for submitting a claim as long as you submit a written request including a copy of the bill from the Provider within the time frame above. 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 claims forms:

Anthem Blue Cross and Blue Shield, P.O. Box 9274, Oxnard, CA 93031-9274.

For information about how your plan works, including your Deductible, the Yearly Maximum Benefit and Maximum Allowable Amount covered 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 Colorado 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 a spouse, domestic partner, legal ward, natural child, adopted child and/or newborn child (except for the first 31 days after birth, adoption or placement for adoption as described below), **are not** eligible for coverage under this Policy. However, those persons may apply for coverage under a separate policy. **Please be aware that an application for coverage does not guarantee coverage; all applications are subject to medical underwriting.**

Children

Newborn children born to the Policyholder, the Policyholder's adopted children or children placed for adoption are eligible for benefits under this Policy for the first 31 days after birth, adoption or placement for adoption. During the first 31-days, Covered Services for a newborn child, adopted child or child placed for adoption shall consist of Medically Necessary care for injury and sickness, including care and treatment of medically diagnosed Congenital Defects and Birth Abnormalities, without regard to the limitations and exclusions applicable to other conditions or procedures covered by Anthem. All Covered Services provided during the first 31 days are subject to the cost sharing requirements, exclusions, limitations, conditions and maximum lifetime benefits that are applicable to other sicknesses, diseases and conditions otherwise covered.

The child is ineligible for benefits under this Policy after the 31st day after birth, adoption or placement for adoption. A parent or legal guardian must apply for coverage within 31 days after the birth of the child, adoption or placement for adoption, and Anthem must approve such application to obtain coverage for the child from the 32nd day and thereafter, subject to the terms, exclusions, limitations and conditions of then available individual coverage. **Please be aware that an application for coverage does not guarantee coverage; all applications are subject to underwriting.**

Your Effective Date

The Effective Date of your coverage is printed on your Anthem Identification (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 made a part of this Policy, are payable in advance and due the first of the month.

There are several payment options available:

- Monthly premium payments are an option if you pay with an automatic checking account deduction (We deduct premium from your checking account every month) or credit card (We charge your credit/debit card every month.
- Bi-monthly or quarterly billing (you will receive a bill in the mail every 2 or 3 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.

If you do not select a payment option, you will receive a bill in the mail every 2 months.

Questions? Visit our web site **tonikhealth.com** or call customer service **1-800-317-9818**

You will be responsible for an additional $25.00 charge for any check or debit which is returned or dishonored by the bank as non-payable to Anthem for any reason.

Important: If you are enrolled in an automated billing program, you must give us at least 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. To make a change, just call us at (800) 317-9818.

Electronic Funds Transfer: If you receive billing statements by mail and you submit a personal check for premium payments, you automatically authorize Anthem 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 your Attained Age. Anthem is not required to notify a Policyholder of a premium increase when a Policyholder enters into a new age bracket. Any change in premiums when a Policyholder enters into a new age bracket will be effective on the next billing date. If a Policyholder's premium is paid beyond the effective date of the change, Anthem may require that the Policyholder pay any additional premium, or accept a refund, whichever is necessary. If the age is misstated, all amounts payable for the correct age shall be adjusted and billed to the Policyholder.

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

This Policy will terminate upon failure to pay premiums when due. A grace period of thirty-one (31) days will be allowed for the payment of premiums. If the premiums are not paid within this thirty-one (31) day grace period, termination will be retroactive to the last date of the period for which premium has been paid. We will not pay for any services provided on or after the date of termination. Any claims paid after termination will be retroactively adjusted.

How Your Coverage Ends

Your coverage under this Policy will end without notice from us:

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 the premiums are not paid within this thirty-one (31) day grace period, termination will be retroactive to the last date of the period for which premium has been paid.

   If this Policy is terminated for non-payment of premiums, your Policy may be reinstated. See the section called Reinstatement in the PART called IMPORTANT INFORMATION ABOUT YOUR PLAN, for information on our reinstatement provision.

2. At the end of the month following a thirty-one (31) day advance notice to Anthem to cancel coverage. We will credit premium paid in advance unless We do not receive the cancellation request at least thirty-one (31) days prior to the effective date of the cancellation.

3. For fraud or intentional misrepresentation of material fact. 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 intentional misrepresentation of material fact 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 Blue Cross and Blue Shield of Colorado and/or Anthem non-group Policy.

6. Upon your death.

7. When you become a permanent Resident outside of Colorado.

8. When Anthem elects not to renew all of its individual dental coverage delivered or issued for delivery in Colorado. Anthem will provide notice of the decision not to renew coverage to those affected Policyholder's and to the Insurance Commissioner in each state in which an affected Policyholder is known to reside at least 180 days prior to the non-renewal of the dental coverage.

9. When the Insurance Commissioner finds that the continuation of the coverage would not be in the best interest of the Policyholder or the coverage is obsolete or would impair Anthem's ability to meet its contractual obligations. Anthem shall provide notice of such discontinuance to each covered Policyholder at least 90 days prior to the date of discontinuance and shall provide the affected Policyholder the opportunity to purchase any other individual health coverage offered by Anthem without regard to the health status of the Policyholder.

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 Services up to the Maximum Allowable Amount counts toward the Deductible so amounts over the Maximum Allowable Amount that a Non-Network Dentist may charge you won't count towards the Deductible. **The Deductible does not apply to diagnostic and preventive services when performed by a Network Dentist.**

B. YEARLY MAXIMUM BENEFIT

All dental benefits are limited to a maximum payment of $500.00 for expense incurred by you during a Year.

C. PAYMENT

Payment is provided as follows for Covered Services incurred. All payments are subject to any maximum amounts, limitations and exclusions as indicated in this Policy. If a Network Dentist provides services, any billed amount above the Maximum Allowable Amount will be a savings to you. Network Dentists have agreed to accept the Maximum Allowable Amount as payment in full. Non-Network Dentists have no such policy with Anthem, therefore, they will bill You for any amounts over the Maximum Allowable Amount in addition to any deductible.

BENEFITS WILL BE PROVIDED ONLY FOR THE SERVICES SPECIFIED IN THIS BENEFIT SCHEDULE. NO BENEFITS WILL BE PROVIDED FOR ANY THING ELSE.

At a Network Dentist benefits will be paid for Covered Services as follows:

- 100% of the Maximum Allowable Amount you incur for diagnostic and preventive services (see Benefit Schedule below for a list of Covered Services) (Deductible is waived); and
- 80% of the Maximum Allowable Amount you incur in excess of the Deductible for fillings (see Benefit Schedule below for a list of Covered Services).

At a Non-Network 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-Network Dentist.

BENEFIT SCHEDULE

Diagnostic and Preventive care

Procedure Code	Brief Description	At a Non-Network Dentist, the Plan Pays
*D0120	Periodic oral exam	$18
*D0140	Limited oral exam-problem focused	$28
*D0150	Initial oral exam	$25
*D0160	Detailed and extensive oral exam-new or established patient	$49
*D0170	Re-evaluation exam-limited, problem focused	$28
*D0180	Comprehensive periodontal exam-new or established patient	$28
**D0210	Full mouth X-rays	$60
D0220	Single (periapical) X-rays – first film	$13
D0230	Single X-rays – additional films	$8
D0240	Single X-rays – Occusal	$17
D0250	Extraoral-first film	$16
D0260	Extraoral-each additional film	$10
D0270	Bitewing X-ray – single film	$16
D0272	Bitewing X-rays – two films	$18
D0274	Bitewing X-rays – four films	$26
D0277	Vertical bitewing X-rays	$16
**D0290	Posterior-anterior or lateral skull and facial bone survey film	$50
**D0330	Panoramic X-ray	$36
**D0340	Cephalometric film	$38
D1110	Prophylaxis (teeth cleaning adult) (limited to 2 per Year)	$39
D1120	Prophylaxis (teeth cleaning child-through age 18) (limited to 2 per Year)	$30
D1201	Prophylaxis (teeth cleaning child-through age 18) with fluoride (limited to 2 per Year)	$35
D1203	Topical fluoride only (child through age 18) (limited to 2 per Year)	$14
D1205	Topical fluoride with Prophylaxis (teeth cleaning adult) (limited to 2 per Year)	$39

***** Exams are limited to two per Year.

****** Full mouth X-rays or its equivalent are limited to one set every three (3) Years.

Fillings

After the Deductible has been satisfied, benefits will be paid for fillings as specified in the following Benefit Schedule. Please note, you may have a greater share of the costs if services are performed by a Non-Network Dentist.

Procedure Code and Brief Description		At a Non-Network Dentist, the Plan Pays
D2140	Amalgam filling – one surface, primary or permanent	$42
D2150	Amalgam filling –two surfaces, primary or permanent	$55
D2160	Amalgam filling – three surfaces, primary or permanent	$72
D2161	Amalgam filling – four or more surfaces, primary or permanent	$84
D2330	Resin-based composite filling – one surface, anterior	$42
D2331	Resin-based composite filling – two surfaces, anterior	$55
D2332	Resin-based composite filling – three surfaces, anterior	$72
D2335	Resin-based composite filling – four surfaces, incisal	$84
D2390	Resin-based composite crown, anterior	$85
***D2391	Resin-based composite filling – one surface, posterior	$42
***D2392	Resin based composite filling – two surfaces, posterior	$55
***D2393	Resin based composite filling – three surfaces, posterior	$72
***D2394	Resin based composite filling – four surfaces, posterior	$84

*** If a tooth or teeth can be restored with amalgam (with the exception of composite resin on anterior teeth) any amount exceeding the cost of that material is not covered if another material is used. Anterior teeth exhibiting pathology eligible for composite restorations are central incisors, lateral incisors, cuspids and the facial surface of bicuspids.

PART 4 WHAT IS NOT COVERED

No benefits are provided for or in connection with the following. They are considered to be exclusions and limitations, which include, but are not limited to the following:

A. **Unlisted Services:** Services not specifically listed in the Benefit Schedule 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 **Maximum Allowable Amount** as determined by Anthem.

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 dependent's such as spouse, domestic partner, legal ward, natural child, adopted child or child placed for adoption (except following birth, adoption or placement for adoption for the first thirty-one (31) days of coverage.

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, except for corporate officers who may opt out of Workers' Compensation coverage. 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 a conditional claims payment during an appeal process if a reimbursement agreement is signed.

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. **Clinical Research:** Services or supplies which are part of clinical research unless We otherwise allow.

M. **Complications of Non-Covered Services:** Complications arising from non-Covered Services and supplies. Examples of non-Covered Services include but are not limited to, Cosmetic Surgery, operations and procedures which are determined to be Experimental/Investigational.

N. **Over the Counter Products:** Items available without a prescription.

O. **Charges for treatment by other than a licensed dentist,** except charges for dental prophylaxis performed by a licensed dental hygienist.

P. **Orthodontic services,** braces appliances and all related services.

Q. **Diagnosis or Treatment of the Joint of the Jaw and/or Occlusion:** Services, supplies or appliances provided in connection with:

1. Any treatment to alter, correct, fix, improve, remove, replace, reposition, restore or otherwise treat the joint of the jaw (temporomandibular joint) or associated musculature, nerves and other tissues for any reason or by any means; or
2. Any treatment, including crowns, and/or bridges to change the way the upper and lower teeth meet (occlusion); or
3. Treatment to change vertical dimension (the space between the upper and lower jaw) for any reason or by any means including the restoration of vertical dimension because teeth have worn down due to attrition, abrasion, abfraction, erosion or bruxism.

R. **Procedures requiring restorations** (other than those for replacement of structure loss from 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.

S. **Oral examinations exceeding two visits per Year.**

T. **Prophylaxis** (teeth cleaning) exceeding two treatments per Year.

U. **More than one set of full-mouth X-rays or its equivalent in a three (3) Year period.**

V. **Fluoride applications:**
- if you are over eighteen (18) years of age.
- exceeding two visits per Year.

W. **Periapical and bite wing x-rays submitted singly** will be combined and paid up to the amount of a full mouth series and are subject to the full-mouth x-ray limitation. No more than two (2) bite wing x-ray series for standard in a Year will be covered. No more than eight (8) films for vertical bite wings in a 36 month period will be covered.

X. **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).

Y. **Fillings exceeding one per Year per surface per tooth** if you are under the age of 19 and one every three (3) Years per surface per tooth if you are over the age of 19.

Z. **If a tooth or teeth can be restored with amalgam** (with the exception of composite resin on anterior teeth) any amount exceeding the cost of that material is not covered if another material is used. Anterior teeth exhibiting pathology eligible for composite restorations are central incisors, lateral incisors, cuspids and the facial surface of bicuspids.

AA. **Replacement of existing fillings** for any purpose other than restoring active decay.

BB. **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, Anthem shall be liable only for the amount it would have been liable for had one Dentist rendered the services.

CC. **Prescribed drugs, pre-medication or analgesia (including nitrous oxide) are excluded.**

DD. **Oral hygiene instruction.**

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

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

GG. **Implants:** (Materials implanted into or on bone or soft tissue), or the removal of implants are not benefits under this Policy.

HH. **Services or Supplies That Are Not Medically Necessary.**

II. **Services for oral surgery,** for example, tooth extractions.

JJ. **Services for endodontics**, for example, root canals. **Endodontics** means the branch of dentistry dealing with diseases of the tooth pulp.

KK. **Services for periodontics**, for example, scaling and root planning. **Periodontics** is the dental specialty of treating periodontal disease.

LL. **Services for prosthodontics,** for example, crowns**. Prosthodontics** is the branch of dentistry dealing with the construction of artificial appliances for the mouth, especially for the purpose of replacing missing teeth with bridges and dentures.

MM. **Space maintainers.** Space maintainers are appliances that are designed to prevent tooth movement.

NN. **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, as determined by Anthem.

OO. **Sealants**.

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 TERMINATION OR RESCISSION OF THIS POLICY AND APPROPRIATE LEGAL ACTION WILL BE TAKEN.

CONFORMITY OF THIS POLICY
Any provision of this Policy which, on or after 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, individual enrollment application/change form, identification card and rate sheet are 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.

POLICYHOLDER OBLIGATION TO SUPPLY INFORMATION AND COOPERATE
You must provide Anthem with any information Anthem considers necessary to determine whether, or to what extent, services are covered under this Policy, or to carry out the other provisions of this Policy.

You agree to cooperate at all times (including while hospitalized) by allowing Anthem access to your medical records to investigate claims and verify information provided in your Enrollment Application/Change Form and/or Health Statement.

If you do not supply information or cooperate as described above, Anthem may deny the claims subject to investigation and Anthem, where permitted by law, may terminate your coverage.

RELATIONSHIP OF PARTIES: We have an independent contractor relationship with Network Dentists who are not Our agents or employees, and Our employees are not employees or agents of any of our Network Dentists. We have no control over any diagnosis, treatment, care or other service provided to you by any Dentist. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any of Network Dentists by reason of negligence or otherwise.

We may subcontract particular services to organizations or entities that have specialized expertise in certain areas. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims payment or customer service duties on our behalf.

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

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

FRAUDULENT INSURANCE ACTS
It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a Policyholder or claimant for the purpose of defrauding or attempting to defraud the Policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

- Be wary of offers to waive Copayments. This practice is usually illegal.
- Be wary of mobile health testing labs. Ask what the insurance company will be charged for the tests.
- Always review the explanation of benefits received from Anthem. If there are any discrepancies, call our customer service department.
- Be very cautious about giving your health insurance coverage information over the phone.

If fraud is suspected, you should contact Anthem's customer service department. Anthem reserves the right to recoup any benefit payments paid on your behalf if you have committed fraud or material misrepresentation in applying for coverage in or receiving or filing for benefits.

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.

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 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.

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

REINSTATEMENT: When failure to pay insurance premiums results in Policy termination, you may have the Policy automatically reinstated retroactive to the termination date by remitting all past due premium **plus** the reinstatement fee of $50.00 within the month following the grace period.

Anthem will not reinstate Polices for which payment of all past due premium plus the restatement fee is not received by Anthem within the month following the grace period. Any amounts received after this date will be returned or refunded to the Policyholder.

If a Policy is not automatically reinstated, you must reapply for a new policy and will be subject to Anthem's underwriting guidelines at the time of application.

Payment to Providers and Provider Reimbursement: Covered Services for Network Dentists are based on the Maximum Allowable Amount. Network Dentists have a Participating Dentist Agreement in effect with us and have agreed to accept the Maximum Allowable Amount as payment in full. Non-Network Dentists do not have a Participating Dentist Agreement with Anthem Blue Cross and Blue Shield. Your personal financial costs when using Non-Network Dentists may be considerably higher than when you use Network Dentists. You will be responsible for any balance of a Dentist's bill which is above the Maximum Allowable Amount payable under this Policy for Non-Network 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 Network Dentists and other Network Providers, whether you have authorized assignment of benefits or not. Anthem may require a copy of the assignment of benefits for our records. We will pay Non-Network 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.

Third Party Liability: Subrogation and Right of Reimbursement:
These provisions apply when Anthem pays benefits as a result of injuries or illness and another party(ies) agrees or is ordered to pay money because of these injuries or when the Policyholder has received or is entitled to receive a Recovery because of these injuries or illnesses.

Subrogation
Anthem has the right to recover payments it makes on the Policyholder's behalf. The following apply:

- Anthem has the first priority lien for the full amount of benefits it has paid from any Recovery, including, but not limited to, the party or parties who caused the injuries or illness, the insurer or other indemnifier of the party or parties who caused the injuries or illness, a guarantor of the party or parties who caused the injuries or illness, the Policyholder's own insurer (for example, in the case of uninsured, underinsured, medical payments or no-fault coverage, a worker's compensation insurer), or any other person, entity, policy or plan that may be liable or legally responsible in relation to the injuries or illness. The Anthem first priority lien exists regardless of whether the Policyholder is fully compensated, and regardless of whether the payments the Policyholder receives makes the Policyholder whole for losses and injuries.

- The Policyholder and the Policyholder's legal representative must do whatever is necessary to enable Anthem to exercise its rights and do nothing to prejudice them.

- Anthem has the right to take whatever legal action it sees fit against any party or entity to recover the benefits paid under this Policy.

- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Anthem subrogation claim and any claim still held by the Policyholder, Anthem subrogation claim shall be first satisfied before any part of a Recovery is applied to the Policyholder's claim, the Policyholder's beneficiary's claims (if applicable), the Policyholder's attorney fees, other expenses or costs.

- Anthem is not responsible for any attorney fees, other expenses or costs incurred without its prior written consent. Anthem and the Policyholder further agree that the "common fund" doctrine does not apply to any funds recovered by any attorney hired regardless of whether funds recovered are used to repay benefits paid by Anthem.

Right of Reimbursement
If the Policyholder, the Policyholder's legal representative, or beneficiary obtain a Recovery and Anthem has not been repaid for the benefits it paid on the Policyholder's behalf, Anthem shall have a first priority lien right to be repaid from the Recovery in the amount of the benefits paid on the Policyholder's behalf and the following apply:

- The Policyholder must reimburse Anthem to the extent of benefits Anthem paid on the Policyholder's behalf from any Recovery, including, but not limited to, the party or parties who caused the injuries or illness, the insurer or other indemnifier of the party or parties who caused the injuries or illness, a guarantor of the party or parties who caused the injuries or illness, the Policyholder's own insurer (for example, in the case of uninsured, underinsured, medical payments or no-fault coverage, a worker's compensation insurer), or any other person, entity, policy or plan that may be liable or legally responsible in relation to the injuries or illness;

- Notwithstanding any allocation made in a settlement agreement or court order, Anthem shall have a right of reimbursement, in first priority, against any Recovery;

- The Policyholder, the Policyholder's legal representative, or beneficiary must hold in trust for Anthem the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Anthem immediately upon receipt of the Recovery. The Policyholder, the Policyholder's legal representative, or beneficiary must reimburse Anthem, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney the Policyholder, the Policyholder's legal representative, or beneficiary may hire regardless of whether funds recovered are used to repay benefits paid by Anthem.

If the Policyholder, the Policyholder's legal representative, or beneficiary fails to repay Anthem, Anthem shall be entitled to deduct any of the unsatisfied portion of the amount of benefits it has paid or the amount of any Recovery whichever is less, from any future benefit under the Policy if:

- The amount Anthem paid is not repaid to or otherwise recovered by Anthem; or
- The Policyholder fails to cooperate or otherwise fulfill the Policyholder's duties, as described in this Policy;
- In the event that the Policyholder, the Policyholder's legal representative, or beneficiary fails to disclose to Anthem the amount of any settlement, Anthem shall be entitled to deduct the amount of its lien from any future benefit under the Policy;
- Anthem shall also be entitled to recover any of the unsatisfied portion of the amount it has paid or the amount of any settlement, whichever is less, directly from the providers to whom Anthem has made payments, to the extent not prohibited by law. In such a circumstance, it may then be the obligation of the Policyholder, the Policyholder's legal representative, or beneficiary to pay the provider the full outstanding amount, and Anthem would not have any obligation to pay the provider;
- Anthem is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make the Policyholder or the recovering party whole.

The Policyholder's Duties

- The Policyholder, the Policyholder's legal representative, or beneficiary must notify Anthem promptly of how, when and where an accident or incident resulting in personal injury or illness to the Policyholder occurred and all information regarding the parties involved.
- The Policyholder, the Policyholder's legal representative, or beneficiary must cooperate with Anthem in the investigation, settlement and protection of its rights.
- The Policyholder, the Policyholder's legal representative, or beneficiary must not do anything to prejudice the rights of Anthem.
- The Policyholder, the Policyholder's legal representative, or beneficiary must send Anthem copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness.
- The Policyholder, the Policyholder's legal representative, or beneficiary must promptly notify Anthem if you retain an attorney or if a lawsuit is filed.
- If the Policyholder, the Policyholder's legal representative, or beneficiary resides in a state where automobile personal injury protection or medical payment coverage is mandatory, that coverage is primary and the Policy takes secondary status. The Policy will reduce benefits for an amount equal to, but not less than, that state's mandatory minimum personal injury protection or medical payment requirement.

NOTE: Failure to comply with obligations in this section may result in termination of coverage under this Policy.

PART 6 IF YOU HAVE A COMPLAINT

Complaints

If you have a complaint about any aspect of Anthem's service or claims processing, you should contact us at (888)-209-7852 or write us at:

Anthem
Customer Service Department
P.O. Box 9274
Oxnard, CA. 93031-9274

A trained representative will work to clear up any confusion and resolve the concerns. If you are not satisfied with the resolution of your concerns, you may file an appeal as explained under the heading Appeals in this section:

Appeals

Your appeal must be submitted in writing. While Anthem encourages you to file appeals within 60 days of the adverse benefit determination, your written appeal must be received by Anthem within 180 days of the adverse benefit determination. Appeals may be for pre-service denials or post-service denials. Anthem will assign a customer advocate to assist the Policyholder in the appeal process. You must send written appeals to the following address:

Anthem
Appeals Department
P.O. Box 9274
Oxnard, CA. 93031-9274

An appeal may be filed with or without first submitting a complaint. In the appeal, you must state plainly the reason(s) why the claim or requested service or supply should not have been denied. You should include any documents not originally submitted with the claim or request for the service or supply and any information that may have a bearing on our decision.

For a thorough, unbiased review, you may access two internal levels of appeal. In the case of a benefit denial based on utilization review, an independent external review appeal is also available to you. For pre-service denials based on utilization review, an expedited appeal and expedited independent external review may be available in certain circumstances.

You may designate a representative (e.g., your Dentist or anyone else of your choosing) to file any level of appeal review with us on your behalf. You must give this designation to us in writing.

The Appeals process is governed by laws and regulations, and may be modified from time to time by Anthem as those laws may require. A more detailed description of the Appeals process and the decision timeframes is set forth in our appeals guide. This guide is available through our website or may be obtained free of charge by calling customer service.

Grievances

You may send a written grievance to the following address:

Anthem
Quality Management Department
P.O. Box 9277
Oxnard, CA. 93031-9277

Receipt of your grievance will be acknowledged by Anthem's Quality Management Department and the grievance will be investigated by Anthem's Quality Management Department. Anthem treats each grievance investigation in a strictly confidential manner.

Division of Insurance

If you have a problem regarding your coverage, please contact Anthem first to resolve the issue. If contacts between you (the complainant) and Anthem Blue Cross and Blue Shield (the Insurer) have failed to produce a satisfactory solution to the problem, you may wish to contact the Division of Insurance. You may call the Division of Insurance between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday, at (303) 894-7490. They can also be reached by writing to:

Division of Insurance to the attention of the ICARE Section
1560 Broadway, Suite 850
Denver, Colorado 80202

Binding Arbitration

Any dispute between you and Anthem must be resolved by binding arbitration and not by lawsuit or resort to court process. Any such arbitration will be governed by the procedures and rules established by the American Arbitration Association, provided however, that no formal discovery shall be allowed, unless agreed to by the parties. You may obtain a copy of the Rules of Arbitration by calling Anthem's customer service department. The law of the state in which the Policy was issued and delivered to the Policyholder shall govern the dispute. The decision in arbitration is binding upon both you and us. Judgment on the award given in arbitration may be enforced in any court that has proper jurisdiction. In the event any person subject to this arbitration clause initiates legal action of any kind, without first complying with this binding arbitration clause, Anthem may apply for a court of competent jurisdiction to enjoin, stay or dismiss any such action and direct the parties to arbitrate in accordance with this provision.

Damages, if any, are limited to the amount of the benefit payment in dispute plus reasonable costs. Anthem is not liable for punitive damages or attorney fees.

Legal Action

Before you take legal action on a claim decision, you must first follow the process outlined under Appeals in this PART and you must meet all the requirements of this Policy. **No action in law or in equity shall be brought to recover on this Policy prior to expiration of 60 calendar days after a claim has been filed 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.

PART 7 NON-DUPLICATION OF ANTHEM BENEFITS

If, while covered under this Individual Policy, you are also covered by another Anthem Blue Cross and Blue Shield 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 8 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. Damage to teeth due to chewing or biting is not an Accidental injury.

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

C. **Attained Age** is your age at the time of each of your premium billings. Your premiums are based upon your Attained Age. We will recalculate your age for each billing, and your premiums will be adjusted accordingly.

D. The **Benefit Schedule** is the list of the maximum amounts payable by Us to Non-Network Dentists for Covered Services. The Benefit Schedule amounts are subject to applicable deductibles and other benefit limitations. The Benefit Schedule may be subject to periodic review and modification.

E. **Birth Abnormalities** are conditions that are recognizable at birth, such as macrognathia or micrognathia.

F. **Coinsurance** is the percentage amount you are responsible for as stated in the Benefit Schedule. Coinsurance does not include charges for services which are not covered or charges in excess of the amount We will allow for payment. These charges are your responsibility and are not included in the Coinsurance calculation.

G. **Congenital Defect** is a defect or anomaly existing before birth, such as cleft lip or club foot. Disorders of growth and development over time are not considered congenital.

H. **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.

I. **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 called WHAT IS COVERED.

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

K. The **Effective Date** is the date your coverage under this Policy begins. It appears on your Identification Card.

L. **Experimental/Investigational procedures are**

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

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

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

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA) or any other state or federal regulatory agency, and such final approval has not been granted.
- Has been determined by the FDA to be contraindicated for the specific use.
- Is provided as part of a clinical research protocol or clinical trial, or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function.
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as Experimental/Investigational, or otherwise indicate that the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation.

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

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

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

- Randomized, controlled, clinical trials published in authoritative, peer-reviewed United States medical or scientific journal.

- Evaluations of national medical associations, consensus panels and other technology evaluation bodies.
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.
- Documents of an IRB or other similar body performing substantially the same function.
- Consent documentation(s) used by the treating Physicians, other medical professionals or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.
- The written protocol(s) used by the treating Physicians, other medical professionals or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.
- Medical records.
- The opinions of consulting providers and other experts in the field

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

M. **In-Network Provider** is a term for Dentists that have entered into a Network agreement with us.

N. The **Maximum Allowable Amount** is the amount Anthem determines is the maximum amount payable for Covered Services, not to exceed charges actually billed. Anthem's determination considers:

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

The amount accepted by a Network Dentist as payment in full under the Network Dentist's participation agreement for this product. After your share Deductible and/or Coinsurance for a Covered Service has been calculated, Anthem pays any remaining amount up to the Maximum Allowable Amount (not to exceed the annual benefit limit).

For Network Dentists, the Maximum Allowable Amount is equal to the amount that constitutes payment in full under the Network Dentist's participation agreement for this product. If a Network Dentist accepts as full payment an amount less than the negotiated rate under the participation agreement, the lesser amount will be the Maximum Allowable Amount.

For a Non-Network Dentist other than a facility, even if the Dentist has a participation agreement with Anthem for another product, the Maximum Allowable Amount is the lesser of the actual charge or our then effective Benefit Schedule.

It is your obligation to pay any Deductibles and any amounts that exceed the Maximum Allowable Amount.

O. **Medically Necessary** an intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that Anthem solely determines to be:

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

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

P. **Non-Network Dentist** is a Dentist who does not have a Participating Dentist Agreement in effect with Anthem at the time services are rendered.

Q. **Network Dentist** is a Dentist who has a Participating Dentist Agreement in effect with us at the time services are rendered. Network Dentists have negotiated certain charges as the Maximum Allowable Amount they will charge you for Covered Services. A list of Network Dentists is available upon request.

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

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

T. **Recovery** is money the you, your legal representative, or beneficiary receives, whether by settlement, verdict, judgement, order or by some other monetary award or determination from another, from their insurer, or from any uninsured motorist, underinsured motorist, medical payments, no-fault, personal injury protection, or any other insurance coverage, as a result of injury or illness to you. Regardless of how you, your legal representative, or beneficiary or any agreement may characterize the money received, it shall be subject to the Subrogation and Right of Reimbursement provisions of this Policy.

U. **Resident** is an individual who maintains legal domicile within the state of Colorado and is presumed, for purposes of this agreement, to be a primary Resident of the state, as evidenced by any three of the following:

- Payment of Colorado income tax
- Employment in Colorado, other than that normally provided on a temporary basis to students
- Ownership of residential real estate property in Colorado
- State identification card or driver' license
- Acceptance of future employment in the state of Colorado
- Vehicle registered in Colorado
- Voter registration in Colorado
- Phone bill or utility bill from Colorado

V. **We** (us, our) refers to Anthem Blue Cross and Blue Shield.

W. **A Year** is a twelve (12) month period starting January 1 at 12:01 a.m. Mountain Standard Time.

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