Anthem

Anthem Blue Cross and Blue Shield
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 (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.

Jude Thompson
President, Individual Business
Anthem Blue Cross and Blue Shield

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INDIVIDUAL ENHANCED TONIK PPO DENTAL PLAN

ISSUED BY

Anthem Blue Cross and Blue Shield (Anthem)

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). 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.

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 that 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.

This is not an annual Policy. The duration of your coverage depends on the method of payment you chose 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 Anthem's 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 as allowed by Colorado state law. 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 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 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 claim 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 deductions, 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.

Duration of your Policy

The Effective Date of your coverage is printed on your Anthem identification card, which is issued together with this Policy and is a part of this Policy.

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 Anthem's monthly checking account deduction 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.

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) Anthem has terminated, canceled, or declined to renew the Policy pursuant to the section entitled HOW YOUR COVERAGE ENDS below; or (2) Anthem has 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 the paragraph above.

How Your Coverage Ends

Anthem 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 the premiums as they become due, Anthem will terminate this Policy as of the last date through 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. On the last day of the month following our receipt of your written notice to cancel.

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 Policyholders 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.

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

Before Anthem will cease to provide any new or existing individual dental benefit Policy:

1. We will give you at least 90 days written notice prior to cessation of this Policy, and

2. Those individual dental benefit policies that are in effect shall not be cancelled for 90 days, after the date of notification to cease coverage, except for specific non-compliance as previously stated under the section **HOW YOUR COVERAGE ENDS** in this Part.

3. 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.

4. In addition to the right to terminate, cancel or decline to renew the Policy set forth in HOW YOUR COVERAGE ENDS, Anthem has the right upon renewal, to modify or otherwise change the terms and conditions of your Policy, including premiums, as allowed by Colorado.

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

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.

2. If your yearly Deductible is not met in a given calendar Year, any amounts you have paid for Covered Services incurred from October through December will 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 toward 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 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.

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

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

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.

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-Network 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	$29
D1510	Space Maintainer-fixed-unilateral	$105
D1550	Recement space maintainers	$22

2. General (Adjunctive) services

Procedure Code and Brief Description		At a Non-Network Dentist, the Plan Pays after Deductible
D9110	Palliative (emergency) treatment of dental pain (limited to once per Year)	$56
D9310	Consultation (diagnostic service provided by Dentist other than practitioner providing treatment) (limited to once per Year)	$61
D9430	Office visit for observation (during regularly scheduled hours) no other services performed (limited to once per Year)	$40

3. Basic Dental Care services

Procedure Code and Brief Description		At a Non-Network Dentist, the Plan Pays after Deductible
D2951	Pin retention-per tooth	$36

4. Oral Surgery services

Procedure Code and Brief Description		At a Non-Network Dentist, the Plan Pays after Deductible
D7140	Extraction – erupted tooth or exposed root	$84
D7210	Surgical removal of erupted tooth	$141
D7220	Removal of impacted tooth – soft tissue	$168
D7230	Removal of impacted tooth – partially bony	$210
D7240	Removal of impacted tooth – completely bony	$279
D9220	General anesthesia	$247

5. Endodontic services

Procedure Code and Brief Description		At a Non-Network Dentist, the Plan Pays after Deductible
D3310	Anterior root canal (excluding final restoration)	$426
D3320	Bicuspid root canal (excluding final restoration)	$509
D3330	Molar root canal (excluding final restoration)	$628

6. Periodontal services

Procedure Code and Brief Description		At a Non-Network Dentist, the Plan Pays after Deductible
D4210	Gingivectomy or gingivoplasty – 4 or more teeth per quadrant	$204
D4211	Gingivectomy or gingivoplasty – one to three teeth per quadrant	$134
D4341	Periodontal scaling and root planing, 4 or more teeth per quadrant	$148

7. Removable Prosthodontics

Procedure Code and Brief Description		At a Non-Network Dentist, the Plan Pays after Deductible
D5110	Complete denture – maxillary	$856
D5120	Complete denture – mandibular	$856
D5211	Maxillary partial denture – resin base	$627
D5212	Mandibular partial denture – resin base	$627
D5213	Maxillary partial denture – cast metal framework with resin denture bases	$992
D5214	Mandibular partial denture – cast metal framework with resin denture bases	$992
D5730	Reline complete maxillary denture (chairside)	$181
D5731	Reline complete mandibular denture (chairside)	$181
D5740	Reline maxillary partial denture (chairside)	$145
D5741	Reline mandibular partial denture (chairside)	$145
D5750	Reline complete maxillary denture (laboratory)	$233

D5751	Reline complete mandibular denture (laboratory)	$233
D5760	Reline maxillary partial denture (laboratory)	$220
D5761	Reline mandibular partial denture (laboratory)	$220

8. Fixed Prosthodontics

Procedure Code and Brief Description		At a Non-Network Dentist, the Plan Pays after Deductible
D2710	Crown – resin (laboratory) (single restoration)	$228
D2720	Crown – resin with high noble metal (single restoration)	$597
D2740	Crown – porcelain/ceramic substrate (single restoration)	$671
D2750	Crown – porcelain fused to high noble metal (single restoration)	$669
D2751	Crown – porcelain fused to predominantly base metal (single restoration)	$623
D2752	Crown – porcelain fused to noble metal (single restoration)	$652
D2780	Crown – ¾ cast high noble metal (single restoration)	$666
D2781	Crown – ¾ cast predominantly base metal (single restoration)	$623
D2782	Crown – ¾ cast noble metal (single restoration)	$649
D2783	Crown – ¾ porcelain/ceramic (single restoration)	$671
D2790	Crown – full cast high noble metal (single restoration)	$633
D2791	Crown – full cast predominantly base metal (single restoration)	$562
D2792	Crown – full cast noble metal (single restoration)	$588
D2930	Prefabricated stainless steel crown – primary tooth	$174
D6210	Pontic – cast high noble metal (fixed partial denture)	$633
D6211	Pontic – cast predominantly base metal (fixed partial denture)	$562
D6212	Pontic – cast noble metal (fixed partial denture)	$588
D6240	Pontic – porcelain fused to high noble metal (fixed partial denture)	$669
D6241	Pontic – porcelain fused to predominantly base metal (fixed partial denture)	$623
D6242	Pontic – porcelain fused to noble metal (fixed partial denture)	$598
D6245	Pontic – porcelain/ceramic (fixed partial denture)	$671
D6250	Pontic – resin with high noble metal (fixed partial denture)	$548
D6251	Pontic – resin with predominantly base metal (fixed partial denture)	$500
D6252	Pontic – resin with noble metal (fixed partial denture)	$552
D6720	Crown – resin with high noble metal (fixed partial denture)	$597
D6721	Crown – resin with predominantly base metal (fixed partial denture)	$500
D6722	Crown – resin with noble metal (fixed partial denture)	$552
D6740	Crown – porcelain/ceramic (fixed partial denture)	$671
D6750	Crown – porcelain fused to high noble metal (fixed partial denture)	$669
D6751	Crown – porcelain fused to predominantly base metal (fixed partial denture)	$623
D6752	Crown – porcelain fused to noble metal (fixed partial denture)	$652
D6780	Crown – ¾ cast high noble metal (fixed partial denture)	$666
D6781	Crown – ¾ cast predominantly base metal (fixed partial denture)	$623
D6782	Crown – ¾ cast noble metal (fixed partial denture)	$649
D6783	Crown – ¾ porcelain/ceramic (fixed partial denture)	$671
D6790	Crown – full cast high noble metal (fixed partial denture)	$633
D6791	Crown – full cast predominantly base metal (fixed partial denture)	$562
D6792	Crown – full cast noble metal (fixed partial denture)	$588

DENTAL CONDITIONS OF SERVICE

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

1. You must incur this expense while you are covered for dental benefits under this Policy. The expense must be 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 Network Dentist or a Non-Network 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 Maximum Allowable Amount 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 Maximum Allowable Amount 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 Maximum Allowable Amount 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 Maximum Allowable Amount 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 **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 dependents 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**.

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

Q. 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.

R. **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.

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

T. **Prophylaxis** (teeth cleaning).

U. **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.

V. **Fluoride applications.**

W. **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).

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

Y. **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.

Z. **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.**

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

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

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

DD. **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.

EE. **Services, Treatments or Supplies That Are Not Medically Necessary**. Medically Necessary services or treatments are those which are ordered by the attending Dentist for the direct care and treatment of a covered condition. They must be standard dental practice where received for the condition being treated and must be legal in the United States**.**

FF**. 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.

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

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

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

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

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

JJ. 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.

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

LL. 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.

MM. Any amounts in excess of the dental benefit maximums and Yearly Maximum Benefit stated in this Policy. The Maximum Allowable Amount 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.

NN. Harmful Habit Appliances: fixed and removable appliances to inhibit thumbsucking, athletic mouthguards.

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

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

QQ. Lost or stolen dentures or appliances. Replacement of existing full or partial dentures or appliances which have been lost or stolen.

RR. 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.

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

TT. The extraction of immature erupting third molars and nonpathologic, except that asymptomatic third molars are covered for age 16 or older.

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

VV. 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.

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

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

YY. 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.

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

AAA. 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.

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

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

DDD. 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.

EEE. 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.

FFF. 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 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 Policies 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 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.

Anthem Blue Cross and Blue Shield provides a toll-free telephone number available during normal business hours to assist you or your provider in obtaining information with respect to Anthem's 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 Anthem's 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 Anthem as those laws and regulations may require.

PART 7 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 8 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 9 IMPORTANT TERMS TO KNOW

Listed below are the definitions of important terms used 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. **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.

G. **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.

H. **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.

I. **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.

J. **Deductible** means the amount of charges you must pay in a 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.

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

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

M. **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.

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

O. 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.

P. **Medically Necessary**, (Medical Necessity) an intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that Anthem 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 Policyholder 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 Policyholder, the Policyholder's family or the provider.
- Not otherwise subject to an exclusion under this Policy.

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.

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

R. **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.

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

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

U**. Recovery** is money that 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.

V. **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.

W**. 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's 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

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

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

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

AA.**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.