SUMMARY OF BENEFITS

The Summary of Benefits is a summary of the Deductibles, Coinsurance and other limits when you receive Covered Services from a Provider. Please refer to the Covered Services section of this Certificate for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of this Certificate including any attachments or riders.

Coverage Year:	Calendar Year
Dependent Age Limit:	Children to Age 26
Benefit Waiting Period:	There are no benefit waiting periods.

DENTAL COVERED SERVICES

After you have satisfied the Deductible, We will pay benefits for Covered Services at the percentage or applicable amount up to the Maximum Allowed Amount for each completed Dental Service. The Maximum Allowed Amount payable for each Dental Procedure is determined by Anthem, and there may be different levels of reimbursement for the Maximum Allowed Amount depending upon whether you elect to receive services from a Participating or a Non-Participating Dentist.

	Participating Dentist	Non-Participating Dentist
Diagnostic and Preventive Services*	100%	100%
Basic Restorative Services	90%	90%
Endodontic Services	90%	90%
Periodontic Services	90%	90%
Oral Surgery Services	90%	90%
Major Restorative Services	60%	60%
Prosthetic Services	60%	60%
Orthodontic Services*	50%	50%

*Not subject to the Deductible

DENTAL BENEFIT MAXIMUMS (combined for Participating and Non-Participating Dentists)

Coverage Year Maximum. Your combined benefits, excluding orthodontics, are subject to the Coverage Year Maximum. We will not pay any benefit in excess of that amount during a Coverage Year.

Orthodontic Services Lifetime Maximum. Your orthodontic benefits are subject to the Orthodontic Services Lifetime Maximum. We will not pay any orthodontic benefits in excess of that amount during a Member's lifetime.

Coverage Year Maximum	Unlimited
Orthodontic Services Lifetime Maximum	$1,500.00

DEDUCTIBLES (combined for Participating and Non-Participating Dentists)

You are responsible for satisfying the Deductibles before We pay for benefits. If 3 family Members satisfy their individual Deductible, the family Deductible will be met. Only charges that are considered a Maximum Allowed Amount will apply toward satisfaction of the Deductibles. **Exception:** The Deductible does not apply to Diagnostic and Preventive or Orthodontic Services.

Per Member	$50
Per Family	$150

Accidental Dental Injury Benefit - No member coinsurance, and/or deductible, or waiting period will apply to services received as a result of an Accident. Accidental Dental Injury benefits are subject to the Coverage Year Maximum. An Accident is defined as an injury that results in physical damage or injury to sound natural teeth and/or the supporting hard and soft tissues as a result of extraoral blunt forces and not due to chewing or biting forces. Sound natural teeth are those that were in good repair prior to the accident and were stable, in functional occlusion, free from decay, fracture and advanced periodontal disease at the time of the accident. The initial claim for the Accident and all claims related to the Accident must be submitted within 12 months following the date of the Accident.

Dental Certificate of Coverage

Note: This policy does not contain the pediatric dental essential health benefits as determined by the Affordable Care Act.

Anthem Dental

Essential Choice Enhanced CA-E77

CHOICE OF DENTIST: This Certificate of Coverage is issued in the state of California. Nothing contained in this Certificate of Coverage restricts or interferes with your right to select the Dentist of your choice, but your benefits are reduced when you use a Dentist who is not a Participating Dentist. Please refer to the section titled "**DENTAL PROVIDERS AND CLAIMS PAYMENTS**" for more information on Participating Dentists, Obtaining a Provider Directory and Timely Access to Care.

DENTAL CERTIFICATE OF COVERAGE

Welcome to Anthem Blue Cross Life and Health Insurance Company (“Anthem”). This Dental Certificate of Coverage (hereinafter "Certificate") has been prepared by Anthem to help explain your dental care benefits. Please refer to this Certificate whenever you require Dental Services. It describes how to access dental care, what Dental Services are covered by Us, and what portion of the dental care costs you will be required to pay.

The coverage described in this Certificate is subject in every respect to the provisions of the Group Dental Contract issued to your Group. The Group Dental Contract and this Certificate and any amendments or riders attached to the same, shall constitute the Group Dental Contract under which Covered Services are provided by Us.

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

Many words used in the Certificate have special meanings. These words appear in capitals and are defined for you. Refer to these definitions in the Definitions section for the best understanding of what is being stated. The Certificate also contains exclusions.

This Certificate supersedes and replaces any Certificate previously issued to you under the provisions of the Group Dental Contract.

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

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DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Accident – An injury that results in physical damage or injury to the sound natural teeth and/or supporting hard and soft tissue structures resulting from extraoral blunt forces and not due to chewing or biting forces. Sound natural teeth are those in good repair that were stable, functional and free from decay, fracture and advanced periodontal disease at the time of the accident.

Actively at Work - Present and capable of carrying out the normal assigned job duties of the Group. Subscribers who are absent from work due to a health related disability, maternity leave or regularly scheduled vacation will be considered Actively at Work.

Appeal - A formal request by you or your representative for reconsideration of an adverse decision on a grievance or claim.

Coverage Year - The period of time that We pay benefits for Covered Services. The Coverage Year is listed in the Summary of Benefits. If your coverage ends earlier, the Coverage Year ends at the same time.

Coverage Year Maximum - The maximum dollar amount payable for Covered Services for each Member during each Coverage Year. If your benefit plan covers orthodontics, benefits for orthodontic services are not included in the Coverage Year Maximum, but are subject to a separate lifetime maximum. Refer to the **Summary of Benefits** for any Coverage Year Maximum or lifetime maximum amounts.

Benefit Waiting Period – The period of continuous coverage under this Certificate that a Member must complete following his or her Effective Date before dental benefits are payable for Covered Services. No payment will be made for expenses incurred during the Benefit Waiting Period indicated in the Summary of Benefits.

Carryover Account. - A separate account used to accumulate unused benefit dollars for use in subsequent Coverage Years to pay Covered Services as outlined in the Maximum Carryover Provision section.

Certificate - This summary of the terms of your benefits. It is attached to and is a part of the Group Dental Contract and it is subject to the terms of the Group Dental Contract.

Coinsurance - A percentage of the Maximum Allowed Amount for which you are responsible to pay. Your Coinsurance will not be reduced by refunds, rebates, or any other form of negotiated post-payment adjustments.

Covered Services - Services or treatment as described in the Certificate which are performed, prescribed, directed or authorized by a Dentist. To be considered Covered Services, services must be:

- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Certificate is in force;
- Not specifically excluded or limited by the Certificate; and
- Specifically included as a benefit within the Certificate.

Deductible - The dollar amount of Covered Services listed in the Summary of Benefits for which you are responsible before We start to pay for Covered Services each Coverage Year.

Dental Service, **Dental Services**, **Dental Procedure** and **Dental Procedures** The providing of dental care or treatment by a Dentist to a Member under this Certificate, provided that such care or treatment is recognized as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dentist – A person who is licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry.

Dependent - A person of the Subscriber's family who is eligible for coverage under the Certificate as described in the Eligibility and Enrollment section.

Effective Date – The date that a Subscriber's coverage begins under this Certificate. You must be Actively at Work on your Effective Date for your coverage to begin. If you are not Actively at Work on your Effective Date, your Effective Date changes to the date that you do become Actively at Work. A Dependent's coverage also begins on the Subscriber's Effective Date.

Eligible Person – A person who meets the Group's requirements and is entitled to apply to be a Subscriber.

Group Dental Contract (or Contract) – The Contract between the Plan and the Group. It includes this Certificate, your application, any supplemental application or change form, and any additional legal terms added by Us to the original Contract. The final interpretation of any specific provision contained in this Certificate is governed by the Group Dental Contract.

Group or **Group Subscriber** – The employer, or other organization, that has entered into a Group Dental Contract with the Plan.

Identification Card / ID Card – A card issued by the Plan, showing the Member's name, membership number, and occasionally coverage information.

Maximum Allowed Amount – The maximum amount of reimbursement Anthem will pay for services provided by a Provider to a Member. You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Coinsurance. There may be different levels of reimbursement for the Maximum Allowed Amount depending upon whether you elect to receive services from a Participating Dentist or a Non-Participating Dentist. The Maximum Allowed Amount will always be the lesser of the maximum amount of reimbursement established by Anthem or the Provider's billed charges.

Maximum Carryover Provision - A plan feature which allows Members to increase their Coverage Year Maximum in subsequent years, if certain requirements are met.

Medically Necessary (Medical Necessity) procedures, services or treatments are those which are:

1. Appropriate and necessary for the symptoms, diagnosis, or treatment of the dental condition;
2. Customarily provided for the prevention, diagnosis, or direct care and treatment of the dental condition;
3. Within standards of good dental practice within the organized dental community;
4 Not primarily for your convenience, or the convenience of your Provider or another Provider; and
5. Based on prevailing dental practices, the least expensive covered service suitable for your dental condition which will produce a professionally satisfactory result.

Member - A Subscriber or Dependent who has satisfied the eligibility conditions, applied for coverage, been approved by the Plan and for whom Premium payment has been made. Members are sometimes called “you” and “your”.

Non-Participating Dentist - A Dentist who has NOT signed a written provider service agreement agreeing to service the program identified in this Certificate. Anthem will reimburse Non-Participating Dentists according to the Maximum Allowed Amount for Non-Participating Dentists.

Open Enrollment - An enrollment period when any eligible Subscriber or Dependent of the Group may apply for this coverage.

Participating Dentist - A Dentist who has signed a written provider service agreement agreeing to service the program identified in this Certificate. The Dentist has agreed to accept the Maximum Allowed Amount as payment in full for dental care covered under this Certificate.

Plan (or We, Us, Our) –Anthem Blue Cross Life and Health Insurance Company. Also referred to as “Anthem.”

Premium - The periodic charges due which the Member or the Group must pay the Plan to maintain coverage.

Pretreatment Estimate – A request by a Member or Dentist to Anthem in advance of a Dental Service being provided to determine the Member’s benefits, estimate the Maximum Allowed Amount, and estimate the amount of the Member’s financial liability. A Pretreatment Estimate is not a guaranty of benefits or a guaranty of payment of benefits.

Prior Plan – The plan sponsored by the Group which was replaced by the benefits under this Certificate within 60 days. You are considered covered under the Prior Plan if you: (1) were covered under the Prior Plan on the date that plan terminated; (2) properly enrolled for coverage within 31 days of this Certificate’s Effective Date; and (3) had coverage terminate solely due to the Prior Plan’s termination.

Provider - A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services that are required by applicable state law to be covered when rendered by such Provider.

Subscriber - An employee or Member of the Group who is eligible to receive benefits under the Group Dental Contract.

ELIGIBILITY AND ENROLLMENT

In this section you will find information on who is eligible for coverage under this Plan and when Members can be added to your coverage. Eligibility requirements are described in general terms below. For more specific information, please see your Human Resources or Benefits Department.

WHO IS ELIGIBLE FOR COVERAGE

Subscriber's Eligibility

a. The person eligible to enroll as a Subscriber is any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal work week of an average of thirty (30) hours per week over the course of a month, at the small employer's regular places of business, and who has met any statutorily authorized applicable waiting period chosen by the Group.

b. Sole proprietors, partners of a partnership, and corporate officers are also eligible to enroll as Subscribers if they are actively engaged on a full-time basis, work at least twenty (20) hours a week in the employer's business and are included as employees under a health care plan contract of the employer.

c. Permanent part-time employees who work at least twenty (20), but not more than twenty-nine (29), hours per week are deemed to be eligible employees if all four (4) of the following apply:

   i. They otherwise meet the definition of an eligible employee except for the number of hours worked.

   ii. The employer offers the employees health coverage under a health benefit plan.

   iii. All similarly situated individuals are offered coverage under the health benefit plan.

   iv. The employee must have worked at least twenty (20) hours per normal work week for at least fifty percent (50%) of the weeks in the previous calendar quarter.

   Note: This applies only if your employer elects to offer coverage to part-time employees and has notified us accordingly.

d. The employees must be in an enrollment class for which the Group makes application to us and which we accept.

Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Group, and be one of the following:

- The Subscriber's spouse as recognized under the laws of the state where the Subscriber lives. For information on spousal eligibility please contact your employer.
- The Subscriber's domestic partner when a domestic partnership has been established by both persons having filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, and, at the time of filing, all additional requirements of domestic partnership under the California Family Code have been met.

  For purposes of this Plan, a domestic partner shall be treated the same as a spouse, and a domestic partner's child, adopted child, or child for whom a domestic partner has legal guardianship shall be treated the same as any other child.

  Any federal or state law that applies to a Member who is a spouse or child under this Plan shall also apply to a domestic partner or a domestic partner's child who is a Member under this Plan. This includes but is not limited to, COBRA, FMLA, and COB. A domestic partner's or a domestic partner's

child's coverage ends on the date of dissolution of the Domestic Partnership.

- The Subscriber's or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the Group has determined are covered under a Qualified Medical Child Support Order as defined by ERISA or any applicable state law.
- Children for whom the Subscriber or the Subscriber's spouse or domestic partner is a legal guardian or as otherwise required by law.

All enrolled eligible children will continue to be covered until the age limit listed in the Summary of Benefits. Coverage may be continued past the age limit in the following circumstances:

- For those already enrolled unmarried Dependents who cannot work to support themselves due to mental retardation or physical handicap. The Dependent's disability must start before the end of the period they would become ineligible for coverage. They may have been covered under this Plan or another plan immediately before being covered under this Plan. We must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the Dependent would normally become ineligible. You must then give proof as often as we require. This will not be more often than once a year after the two-year period following the child reaching the limiting age. You must give the proof at no cost to us. You must notify us if the Dependent's marital status changes and they are no longer eligible for continued coverage.

We may require you to give proof of continued eligibility for any enrolled child. Your failure to give this information could result in termination of a child's coverage.

To obtain coverage for children, we may require you to give us a copy of any legal documents awarding guardianship of such child(ren) to you.

Types of Coverage
Your Group offers the enrollment options listed below. After reviewing the available options, you may choose the option that best meets your needs. The options are as follows:

- Subscriber only (also referred to as single coverage);
- Subscriber and spouse or domestic partner;
- Subscriber and child(ren);
- Subscriber and family.

WHEN YOU CAN ENROLL

Initial Enrollment
The Group will offer an initial enrollment period to new Subscribers and their Dependents when the Subscriber is first eligible for coverage. Coverage will be effective based on any statutorily authorized applicable waiting period chosen by the Group.

If you did not enroll yourself and/or your Dependents during the initial enrollment period you will only be able to enroll during an Open Enrollment period or during a special enrollment period, as described below.

Open Enrollment
Open Enrollment refers to a period of time during which eligible Subscribers and Dependents can apply for or change coverage. Open Enrollment occurs only once per year. The Group will notify you when Open Enrollment is available.

Special Enrollment Periods
If a Subscriber or Dependent does not apply for coverage when they are first eligible, they may be able to enroll in or change health benefit plans as a result of the following triggering events:

- He or she or his or her Dependent loses minimum essential coverage, as described in California Health and Safety Code Section 1357.500 (d);
- He or she gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption (please see "Important Notes about Special Enrollment" below);
- He or she is mandated to be covered as a Dependent pursuant to a valid state or federal court order;
- He or she has been released from incarceration;
- His or her health coverage issuer substantially violated a material provision of the health coverage contract;
- He or she gains access to new health benefit plans as a result of a permanent move;
- He or she was receiving services from a contracting provider under another health benefit plan, for one of the conditions described in subdivision (c) of Health and Safety Code Section 1373.96 and that provider is no longer participating in the health benefit plan;
- He or she is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service;
- He or she demonstrates that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period because he or she was misinformed that he or she was covered under minimum essential coverage;
- He or she lost employer contributions towards the cost of the other coverage.

Important Notes about Special Enrollment

- Members who enroll during special enrollment are **not** considered late enrollees.
- Individuals must apply for coverage within 60 days of the date of the triggering event.
- Coverage for individuals who apply during one of the specified special enrollment periods becomes effective:
    - No later than the first day of the first calendar month beginning after the date the Plan receives the request for special enrollment;
    - In the case of birth, adoption, or placement for adoption, the child will be covered for the first 31 days from the date of birth, adoption, or placement for adoption. Coverage will continue beyond the 31 days, provided that you submit an application / change form to the Group within 60 days from the date of the birth, adoption, or placement for adoption to add the child to your Plan. If you submit an application / change form to the Group within 60 days from the date of birth, adoption, or placement for adoption, coverage for the child under your Plan will be effective beginning on the date of birth, adoption, or placement for adoption.
        - A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

To request special enrollment or obtain more information, call us at the Customer Service telephone number on your Identification Card, or contact the Group.

Late Enrollees
If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a special enrollment period, they will not be eligible to enroll until the next open enrollment period.

Members Covered Under the Group's Prior Plan
Members who were previously enrolled under another plan offered by the Group that is being replaced by

this Plan are eligible for coverage on the Effective Date of this coverage.

UPDATING COVERAGE AND/OR REMOVING DEPENDENTS
You are required to notify the Group of any changes that affect your eligibility or the eligibility of your Dependents for this Plan. When any of the following occurs, contact the Group and complete the appropriate forms:

- Changes in address;
- Marriage or divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare;
- Dependent child reaching the Dependent Age Limit as listed in the Summary of Benefits (see the section Termination and Continuation);
- Enrolled Dependent child either becomes totally or permanently disabled, or is no longer disabled.

All notifications must be in writing and on approved forms.

TERMINATION AND CONTINUATION

Except as otherwise provided, your coverage may terminate in the following situations. The information provided below is general and the actual effective date of termination may vary based on your Group's agreement with Us and your specific circumstances, such as whether Premium has been paid in full.

Termination of Coverage

Your coverage and that of your eligible Dependents ceases on the earliest of the following dates:

a) The end of the month in which (1) you cease to be eligible; (2) your Dependent is no longer eligible as a Dependent under the Certificate.

b) On the date the Certificate is terminated.

c) On the date the Group terminates the Certificate by failure to pay the Premiums, except as a result of inadvertent error.

d) The date contribution for coverage under the Certificate is not made when due.

For extended eligibility, see Continuation of Coverage.

Continuation of Coverage (COBRA)

Dental benefits may be continued should any of the following events occur, provided that at the time of occurrence this Certificate remains in effect and you or your spouse or your Dependent child is a Member under this Certificate:

QUALIFYING EVENT	WHO MAY CONTINUE	MAXIMUM CONTINUATION PERIOD
Employment ends, retirement, leave of absence, lay-off, or employee becomes ineligible (except gross misconduct dismissal)	Subscriber and Dependents	Earliest of: 1. 18 months, or 2. Enrollment in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Divorce, marriage dissolution, or legal separation	Former spouse and any Dependent children who lose coverage	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Death of Subscriber	Surviving spouse and Dependent children	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage or Medicare, or

		3. Date coverage would otherwise end.

Dependents lose eligibility due to Subscriber's entitlement to Medicare	Spouse and Dependents	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Subscriber's total disability	Subscriber and Dependents	Earliest of: 1. 29 months, or 2. Date total disability ends, or 3. Enrollment date in other group coverage or Medicare.
Retirees of employer filing Chapter 11 bankruptcy (includes substantial reduction in coverage within 1 year of filing)	Retiree and Dependents	Earliest of: 1. Enrollment date in other group coverage, or 2. Death of retiree or Dependent electing COBRA.
Surviving Dependents of retiree on lifetime continuation due to the bankruptcy of the employer	Surviving spouse and Dependents	Earliest of: 1. 36 months following retiree's death, or 2. Enrollment date in other group coverage.

You or your eligible Dependents have 60 days from the date you lose coverage, due to one of the events described above, to inform the Group that you wish to continue coverage; except that, in the case of death of an eligible employee, divorce, legal separation, an employee's eligibility for Medicare or a dependent child ceasing to meet eligibility requirements, such notification period to continue coverage shall be 90 days.

1. Choosing Continuation

   If you lose coverage, your employer must notify you of the option to continue coverage within 10 days after employment ends. If coverage for your Dependent ends because of divorce, legal separation, or any other change in Dependent status, you or your covered Dependents must notify your employer within 60 days.

   You or your covered Dependents must choose to continue coverage by notifying the employer in writing. You or your covered Dependents have 60 days to choose to continue, starting with the date of the notice of continuation or the date coverage ended, whichever is later. Failure to choose continuation within the required time period will make you or your covered Dependents ineligible to choose continuation at a later date. You or your covered Dependents have 45 days from the date of choosing continuation to pay the first continuation charges. After this initial grace period, you or your covered Dependents must pay charges monthly in advance to the employer to maintain coverage in force.

   Charges for continuation are the group rate plus a two percent administration fee. All charges are paid directly to your employer. If you or your covered Dependents are totally disabled, charges for continuation are the group rate plus a two percent administration fee for the first 18 months. For months 19 through 29, the employer may charge the group rate plus a 50 percent administration fee.

2. Second qualifying event

   If a second qualifying event occurs during continuation, a Dependent qualified beneficiary may be entitled to election rights of their own and an extended continuation period. This rule only applies

when the initial qualifying event for continuation is the employee's termination of employment, retirement, leave of absence, layoff, or reduction of hours.

When a second qualifying event occurs such as the death of the former covered employee, the Dependent must notify the employer of the second event within 60 days after it occurs in order to continue coverage. In no event will the first and second period of continuation extend beyond the earlier of the date coverage would otherwise terminate or 36 months.

A qualified beneficiary is any individual covered under the health plan the day before the qualified event as well as a child who is born or placed for adoption with the covered employee during the period of continuation coverage.

3. Terminating Continuation of Coverage - COBRA

Continuation of Coverage - COBRA for you and your eligible Dependents, if selected, shall terminate on the last day of the month in which any of the following events first occur:

a) The expiration of the specified period of time for which Continuation of Coverage - COBRA can be maintained; as mandated by applicable State or Federal law;

b) This Certificate is terminated by the Group Subscriber;

c) The Group Subscriber's or Member's failure to make the payment for the Member's Continuation of Coverage

Questions regarding Continuation of Coverage - COBRA should be directed to your employer. Your employer will explain the regulations, qualifications and procedures required when you continue coverage.

CONTINUATION OF COVERAGE – CAL-COBRA

If the Group is an Employer with between two (2) and nineteen (19) full-time, permanent, active employees on a typical business day, you may be entitled, in accordance with these provisions, to continue for a limited period of time coverage that would otherwise end. In order to continue coverage, you must qualify as described below, and you and the Group must also satisfy the requirements set out below.

DEFINITIONS

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appears in these provisions, the first letter of each word will appear in capital letters. When you see these capitalized words, you should refer to this DEFINITIONS provision.

Initial Enrollment Period is the period of time following the original Qualifying Event, as indicated in the TERMS OF CAL-COBRA CONTINUATION provisions below.

Qualified Beneficiary means: (a) a person enrolled for this Cal-COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this Certificate as either a Subscriber or Dependent, (b) a Child who is born to or placed for adoption with the Subscriber during the Cal-COBRA continuation period, or (c) a Child for whom the Subscriber or Spouse has been appointed permanent legal guardian by final court decree or order during the Cal-COBRA continuation period. Qualified Beneficiary does not include any person who was not enrolled during the Initial Enrollment Period, including any Dependents acquired during the Cal-COBRA continuation period, with the exception of newborns, adoptees, and children of permanent legal guardians as specified above.

Qualifying Event means any one of the following circumstances which would otherwise result in the termination of your coverage under the Certificate. The event will be referred to throughout this section by letter/number.

A. **For Subscribers and Dependents**:

1. The Subscriber's termination of employment, for any reason other than gross misconduct; or
2. A reduction in the Subscriber's work hours.

B. **For Dependents**:

1. The death of the Subscriber;
2. The Spouse's divorce or legal separation from the Subscriber;
3. The end of a Child's status as a Dependent Child, as defined by the Certificate;
4. The Subscriber's entitlement to Medicare; or
5. The loss of eligible status by an enrolled Dependent.

ELIGIBILITY FOR CAL-COBRA CONTINUATION

A Subscriber or Dependent may choose to continue coverage under the Certificate if his or her coverage would otherwise end due to a Qualifying Event.

Exception: A Qualified Beneficiary is not entitled to continue coverage if, at any time of the Qualifying Event: (1) the Qualified Beneficiary is entitled to Medicare; (2) the Qualified Beneficiary is covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the Qualified Beneficiary; (3) we fail to receive timely notice of the Qualifying Event or election, as set out below, of a Cal-COBRA continuation, or (4) the Qualified Beneficiary fails to submit the required premium as set out below. If one Qualified Beneficiary is unable to continue coverage for these reasons, other entitled qualified beneficiaries may still choose to continue their coverage.

TERMS OF CAL-COBRA CONTINUATION

1. For Qualifying Event A., above, the Group must notify the Subscriber and us within 31 days of the Qualifying Event of the right to continue coverage. We in turn must, within 14 days, give you official notice of the Cal-COBRA continuation right.
2. You must inform us within 60 days of the Qualifying Event B., above, if you wish to continue coverage. We in turn must within 14 days give you official notice of the Cal-COBRA continuation right.

If you choose to continue coverage, you must notify us within 60 days of the date you receive notice of your Cal-COBRA continuation right. The Cal-COBRA continuation coverage may be chosen for all qualified beneficiaries within a covered family, or only for selected qualified beneficiaries.

If you fail to elect the Cal-COBRA continuation during the Initial Enrollment Period, you may not elect the Cal-COBRA continuation at a later date.

The initial premium must be delivered to us within 45 days after you elect Cal-COBRA continuation coverage.

An election of continuation coverage must be in writing and delivered to us by first class mail or other reliable means of delivery, including personal delivery, express mail or private courier company. The initial premium must be delivered to us at Anthem Blue Cross Life and Health Insurance Company, P.O. Box 9062, Oxnard, CA 93031-9062 by certified mail or other reliable means of delivery, including personal delivery, express mail or private courier company, and must be in an amount sufficient to pay all

premiums due. **A failure to properly give notice of an election of continuation coverage or a failure to properly and timely pay premiums due will disqualify you from continuing coverage**.

Additional Dependents. A Child acquired during the Cal-COBRA continuation period is eligible to be enrolled as an Qualified Beneficiary. The standard enrollment provisions of the Certificate apply to enrollees during the Cal-COBRA continuation period. A Dependent acquired and enrolled after the effective date of continuation coverage resulting from the original Qualifying Event is not eligible for a separate continuation if a subsequent Qualifying Event results in the person's loss of coverage.

Cost of Coverage. The Group may require that you pay the entire cost of your Cal-COBRA continuation coverage. This cost, called the "premium", must be remitted to us each month during the Cal-COBRA continuation period and shall be up to 110% of the rate applicable to a Qualified Beneficiary for whom a Qualifying Event has not occurred. **We must receive proper and timely payment of the premium each month from you in order to maintain the coverage in force**.

Besides applying to the Subscriber, the Subscriber's rate also applies to:

1. A Spouse whose Cal-COBRA continuation began due to divorce, separation or death of the Subscriber;

2. A Child if neither the Subscriber nor the Spouse has enrolled for this Cal-COBRA continuation coverage (if more than one Child is so enrolled, the premium will be based on the two-party or three-party rate depending on the number of Children enrolled); and

3. A Child whose Cal-COBRA continuation began due to the person no longer meeting the Dependent Child definition.

Subsequent Qualifying Events. Once covered under the Cal-COBRA continuation, it is possible for a second Qualifying Event to occur. If that happens, a Qualified Beneficiary who is a Qualified Beneficiary may be entitled to an extended Cal-COBRA continuation period. This period will in no event continue beyond 36 months from the date of the first Qualifying Event.

For example, a Child may have been originally eligible for Cal-COBRA continuation due to termination of the Subscriber’s employment, and enrolled for this Cal-COBRA continuation as a Qualified Beneficiary. If, during the Cal-COBRA continuation period, the Child reaches the upper age limit of the plan, the Child is eligible to remain covered for the balance of the continuation period which would end no later than 36 months from the date of the original Qualifying Event (the termination of employment).

When Cal-COBRA Continuation Begins. When Cal-COBRA continuation coverage is elected during the Initial Enrollment Period and the premium is paid, coverage is reinstated back to the date of the original Qualifying Event, so that no break in coverage occurs.

For Dependents properly enrolled during the Cal-COBRA continuation, coverage begins according to the enrollment provisions of the Certificate.

When the Cal-COBRA Continuation Ends - For Qualified beneficiaries, **this continuation will end on of the earliest of**:

1. The end of thirty-six (36) months from the Qualifying Event;*
2. The date the certificate terminates;
3. The end of the period for which premiums are last paid;
4. The date the Qualified Beneficiary becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the

Qualified Beneficiary, in which case this Cal-COBRA continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or

5. The date the Qualified Beneficiary becomes eligible for Medicare.

*For an Qualified Beneficiary whose Cal-COBRA continuation coverage began under a prior plan, this term will be dated from the time of the Qualifying Event under that prior plan.

If your Cal-COBRA continuation coverage under this plan ends because the Group replaces our coverage with coverage from another company, the Group must notify you at least thirty (30) days in advance and let you know what you have to do to enroll for coverage under the new plan for the balance of your Cal-COBRA continuation period.

POST CAL-COBRA CONTINUATION OF COVERAGE FOR QUALIFYING EVENTS OCCURRING FOR AGES 60 AND OVER

Note: This section ("POST CAL-COBRA CONTINUATION OF COVERAGE FOR QUALIFYING EVENTS OCCURRING FOR AGES 60 AND OVER") applies ONLY to Qualified Beneficiaries turning sixty (60) years of age prior to January 1, 2005.

Subject to payment of premiums stated in the Certificate, coverage under this Plan may be continued for the Subscriber, the Subscriber's Spouse and the Subscriber's former Spouse (if any) under Section 10116.5 of the Insurance Code, in accordance with the following provisions. This continuation may be elected following the Cal-COBRA CONTINUATION OF COVERAGE shown above.

For the purpose of this section, "former Spouse" means (a) an individual who is divorced from the Subscriber; or (b) an individual who was married to the Subscriber at the time of the Subscriber's death.

Requirements: The Subscriber and Spouse may continue coverage under this Plan if:

A. The Subscriber, or the Subscriber on behalf of himself or herself and the Spouse, was entitled to, and had elected to continue coverage under Cal-COBRA as described in the preceding section;

B. The Subscriber or Spouse has not elected to continue coverage under any other available continuation;

C. The Subscriber has worked for the employer for at least the prior five (5) years, and

D. The Subscriber is at least 60 years old on the date employment with the Group ended.

The former Spouse may continue coverage under this plan in accordance with this section if he or she was covered as a Qualified Beneficiary under Cal-COBRA.

TERMS OF CAL-COBRA EXTENSION OF CONTINUATION OF COVERAGE

Note: **This section ("TERMS OF CAL-COBRA EXTENSION OF CONTINUATION OF COVERAGE") applies ONLY to Qualified Beneficiaries turning sixty (60) years of age prior to January 1, 2005**.

Notice and Election. We will notify you and your Spouse or former Spouse of the right to an extension in your continuation of coverage at least 90 days prior to the date continuation of coverage under Cal-COBRA is scheduled to end.

If you choose to continue coverage, you must notify us in writing within 30 days prior to the end of your Cal-COBRA continuation period.

If you fail to elect the extended Cal-COBRA continuation during the Post Cal-COBRA election period, you may not elect the Cal-COBRA continuation at a later date.

Cost of Coverage. The Group may require that you pay the entire cost of your Cal-COBRA extended coverage. This cost, called the "premium", must be remitted to us each month during the Cal-COBRA extended continuation period and shall be up to 110% of the rate applicable to a Qualified Beneficiary for whom a Qualifying Event has not occurred. **We must receive proper and timely payment of the premium each month from you in order to maintain the coverage in force**.

Besides applying to the Subscriber, the Subscriber's rate also applies to a Spouse or former Spouse whose Cal-COBRA continuation began due to divorce, separation or death of the Subscriber.

When Post Cal-COBRA Continuation Ends. This continuation will end on the earliest of:

1. The date the Certificate terminates;
2. The end of the period for which premiums are last paid;
3. The date the Qualified Beneficiary becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the Qualified Beneficiary, in which case this Cal-COBRA continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or
4. The date the Qualified Beneficiary becomes eligible for Medicare.
5. For a Spouse or Former Spouse of the Subscriber, five (5) years from the date on which continuation coverage under Cal-COBRA was scheduled to end for the Subscriber.
6. The date on which the employer or former employer terminates its group Subscriber Certificate with the health care service plan and no longer provides coverage for any active employees through the plan.

DENTAL PROVIDERS AND CLAIMS PAYMENT

You do not have to select a particular Dentist to receive dental benefits. You have the freedom to choose the Dentist you want for your dental care. However, your Dentist choice can make a difference in the benefits you receive and the amount you pay. You may have additional out-of-pocket costs if your Dentist is a Non-Participating Dentist. There may be differences in the payment amount compared with a Participating Dentist if your Dentist is a Non-Participating Dentist.

PAYMENTS ARE MADE BY ANTHEM ONLY WHEN THE COVERED DENTAL PROCEDURES HAVE BEEN COMPLETED. THE PLAN MAY REQUIRE ADDITIONAL INFORMATION FROM YOU OR YOUR PROVIDER BEFORE A CLAIM CAN BE CONSIDERED COMPLETE AND READY FOR PROCESSING. IN ORDER TO PROPERLY PROCESS A CLAIM, THE PLAN MAY BE REQUIRED TO ADD AN ADMINISTRATIVE POLICY LINE TO THE CLAIM. DUPLICATE CLAIMS PREVIOUSLY PROCESSED WILL BE DENIED.

Requests for information is subject to all applicable California confidentiality requirements, including California laws that prohibit use of HIV and or AIDS/ARC status for purposes of determining insurability.

This section describes how We determine the amount of reimbursement for Covered Services. Reimbursement for Dental Services rendered by Participating and Non-Participating Dentists is based on the Maximum Allowed Amount for the type of service performed. There may be different levels of reimbursement for the Maximum Allowed Amount depending upon whether you elect to receive services from a Participating or a Non-Participating Dentist.

The Maximum Allowed Amount is the maximum amount of reimbursement Anthem will pay for Dental Services provided by a Dentist to a Member and which meet our definition of a Covered Service.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Coinsurance. In addition, when you receive Covered Services from a Non-Participating Dentist, you may be responsible for paying any difference between the Maximum Allowed Amount and the Dentist's actual charges. This amount may be significant.

When you receive Covered Services from a Dentist, we will apply processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and determine whether the provider submitted the claim with the correct dental procedure code(s). Applying these rules may affect the Maximum Allowed Amount. For example, your Dentist may have submitted the claim using several procedure codes when there is a single procedure code that includes all or a combination of the procedures that were performed. When this occurs, our payment will be based on a single Maximum Allowed Amount for the single procedure code rather than a separate Maximum Allowed Amount for each billed procedure amount.

Likewise, when multiple procedures are performed on the same day by the same dental Provider or other dental Providers, We may reduce the Maximum Allowed Amount for those additional procedures, because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent a duplicate payment for a Dental Procedure that may be considered incidental or inclusive.

IMPORTANT: If you opt to receive dental services that are not covered services under this policy, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost for each service. If you would like more information about dental coverage options, you may call member services at (844) 729-1565 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Dentist or a Non-Participating Dentist. There may be different levels of reimbursement for the Maximum Allowed Amount depending upon whether you elect to receive services from a Participating Dentist or a Non-Participating Dentist.

Participating Dentists in California

A Participating Dentist is a Dentist who has signed a written provider service agreement agreeing to service the program identified in this Certificate. For Covered Services performed by a Participating Dentist, the Maximum Allowed Amount is the rate the Dentist has agreed to accept as reimbursement for Covered Services or the Dentist's actual charges, whichever is less. Because Participating Dentists have agreed to accept the Maximum Allowed Amount as payment in full for services, they should not send you a bill or collect for amounts above the agreed upon Maximum Allowed Amount. However, you may receive a bill or be asked to pay a portion of the Maximum Allowed Amount to the extent you have exhausted your coverage for the service, have not met your Deductible, have a Coinsurance, have received non-covered services, or have exceeded the dental benefit maximum as outlined in the Summary of Benefits. Please call Member Services at (844) 729-1565 for help in finding a Participating Dentist or visit our website at www.anthem.com.

Participating Dentists Outside of California
If you do not live at the residence of the Subscriber or live outside the California service area for your plan, there are Participating Dentists who have signed a written provider service agreement agreeing to service the Anthem programs in other states. There are several ways to find a Participating Dentist for your dental care. They include:

- Visit our website to obtain a provider directory for Participating Dentists who participate in our program in the area in which you reside. The website address is www.anthem.com. Once you are on the website, click on Menu and then Find a Doctor. You can search as a Member using your Anthem ID card to make sure you find a Participating Dentist who accepts your plan;
- Call our Member Service Department at the telephone number listed on your Identification Card, which is (844) 729-1565 for assistance.

If we are unable to find an available Participating Dentist for your dental care, you may choose any Non-Participating Dentist. Upon completion of your dental services, request a receipt from the Non-Participating Dentist and send it to us for reimbursement. Your financial responsibility will be the Coinsurance that you would have paid in a Participating Dentist office subject to the Deductible, exclusions, limitations and benefit maximums of your plan. Our payment will be the lessor of the Maximum Allowed Amount (s) for the covered dental services or the Non-Participating Dentist's usual fee for service, subject to the exclusions, limitations and benefit maximums of your plan.

Non-Participating Dentists

Dentists who have NOT signed a written provider service agreement agreeing to service the program identified in this Certificate are considered Non-Participating Dentists. For Covered Services you receive from a Non-Participating Dentist, the Maximum Allowed Amount will be the lesser of the Dentist's actual charges or an amount based on Our Non-Participating provider fee schedule/rate, which We reserve the right to modify from time to time, after considering one or more of the following: record fee data, reimbursement amounts accepted by like/similar providers contracted with Anthem, reimbursement amounts accepted by like/similar providers for the same services or supplies, or other industry cost, reimbursement and utilization data.

Unlike Participating Dentists, Non-Participating Dentists may send you a bill and collect for the amount of the Dentist's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Non-Participating Dentist charges.

This amount may be significant. Choosing a Participating Dentist will likely result in lower out of pocket costs to you. Please call Customer Service Department at (844) 729-1565 for help in finding a Participating Dentist or visit Our website at www.anthem.com.

Customer Service is also available to assist you in determining the Maximum Allowed Amount for a particular service from a Non-Participating Dentist. In order for Us to assist you, you will need to obtain the specific procedure code(s) from your Dentist for the services the Dentist will render. You will also need to know the Dentist's charges to calculate your out of pocket responsibility. Although Customer Service can assist you with this pre-service information, the Maximum Allowed Amount for your claim will be based on the actual claim submitted.

EMERGENCY CARE

Emergency care is dental service(s) provided for the treatment or alleviation of severe pain, uncontrollable bleeding, or swelling. All Participating Dentists for your plan located in and outside of California are available for emergency care twenty-four hours a day, seven days a week. If possible, you should get emergency care from your Participating Dentist. In some circumstances, such as where there is no Participating Dentist available, we may authorize the participating cost share amounts (Deductible and Coinsurance) to apply to a claim for a Covered Service you receive from a Non-Participating Dentist.

In such circumstance, you must contact us in advance of obtaining the Covered Service. We also may authorize the participating cost share amounts (Deductible and Coinsurance) to apply to a claim for Covered Services if you receive Emergency services from a Non-Participating Dentist or you're temporarily out of the state and are not able to contact us until after the Covered Service is rendered. If we authorize a Covered Service so that you are responsible for the participating cost share amounts, you may still be liable for the difference between the Maximum Allowed Amount and the Non-Participating Dentist's charge

PROVIDER DIRECTORIES

If you need a provider directory to choose a provider who participates in your Plan's network, there are several ways to obtain one:

- Visit our website at www.anthem.com. Once you are on the website, click on Menu and then Find a Doctor. You can search as a Member using your Anthem ID card to make sure you find a Participating Dentist who accepts your plan; or
- Call Member Services at 844-729-1565. This number is also listed on your Identification Card.

Please note that we have several networks and that a provider who participates for one plan may not participate for another. Be sure to check your Identification Card or call Member Services to find out which network this Plan uses.

TIMELY ACCESS TO CARE

Anthem has contracted with Participating Dentists to provide Covered Services in a manner appropriate for your condition, consistent with good professional practice. Anthem ensures that its network of Participating Dentists have the capacity and availability to offer appointments within the following timeframes:

- Urgent care appointments: within 72 hours of the request for an appointment;
- Non-urgent appointments for primary care: within 36 business days of the request for an appointment; and
- Preventive dental care appointments: within 40 business days of the request for an appointment.

If a Participating Dentist determines that the waiting time for an appointment can be extended without a detrimental impact on Your health, the Participating Dentist may schedule an appointment for a later time than noted above. Participating Dentists are required to have an answering service or a telephone

answering machine during non-business hours, which will provide instructions on how you can obtain urgent or emergency care including, when applicable, how to contact another dentist who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.
If you need the services of an interpreter, the services will be coordinated with scheduled appointments and will not result in a delay of your appointment.

If you have complaints regarding your ability to access needed dental care in a timely manner, you may complain to Anthem and to the California Department of Insurance. Please see the "**CONTACTING CALIFORNIA DEPARTMENT OF INSURANCE**" section of this Certificate.

ACCESS TO MEDICALLY APPROPRIATE CARE FROM A QUALIFIED PROVIDER
Our Participating Dentists in your program must provide access to medically appropriate care from a qualified provider. If medically appropriate care cannot be provided by our Participating Dentists, then Anthem shall arrange for the required care with an available and accessible Non-Participating Dentist, Your financial responsibility will be the Coinsurance that you would have paid in a Participating Dentist office subject to the Deductible, exclusions, limitations and benefit maximums of your plan. Our payment will be the lessor of the Maximum Allowed Amount (s) for the covered dental services or the Non-Participating Dentist's usual fee for service, subject to the exclusions, limitations and benefit maximums of your plan.

MEMBER COST SHARE

For certain Covered Services and depending on your dental program, you may be required to pay a part of the Maximum Allowed Amount (for example, Deductible and/or Coinsurance). Your Deductible and Coinsurance cost share amount and out-of-pocket limits may vary depending on whether you received services from a Participating or Non-Participating Dentist. Specifically, you may pay higher cost sharing amounts or incur benefit limits when using Non-Participating Dentists. Please see the Summary of Benefits in this Certificate for your cost share responsibilities and limitations, or call Member Services to learn how this Certificate's benefits or cost share amounts may vary by the type of Dentist you use.

Payment of Benefits

We will make payments directly to Participating Dentists for Covered Services. We also reserve the right to make payments directly to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by Us will discharge Our obligation to pay for Covered Services.

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

THE MEMBER IS RESPONSIBLE FOR ALL TREATMENT CHARGES MADE BY A NON-PARTICIPATING DENTIST. WHEN SERVICES ARE OBTAINED FROM A NON-PARTICIPATING DENTIST, ANY BENEFITS PAYABLE UNDER THE GROUP CONTRACT ARE PAID DIRECTLY TO THE MEMBER.

Notice of Claim

Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the insurer at P.O. Box 1115, Minneapolis, Minnesota 55440 or to any authorized agent of the insurer, with information sufficient to identify the insured employee, shall be deemed notice to the insurer.

Claim Forms

Anthem, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. Such proof must include:

- Name of patient
- Patient's relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the Provider's signature

Claims should be submitted to:

Anthem Blue Cross Life and Health Insurance Company
PO Box 1115
Minneapolis, MN 55440-1115
(844) 729-1565

Proof of Loss

Written proof of loss must be furnished to the insurer, in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which the insurer is liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the employee, later than one year from the time proof is otherwise required.

Time of Payment of Claim

Indemnities payable under this policy for any loss other than loss for which this policy provides periodic payments will be paid (to the insured employee) as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which this policy provides periodic payment will be paid (to the insured employee) and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

Payment of Claims

Indemnities payable under this policy for any loss other than loss for which this policy provides periodic payments will be paid (to the insured employee) as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which this policy provides periodic payment will be paid (to the insured employee) and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

Explanation of Benefits

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

- total amounts charged for services/supplies received;
- the amount of the charges satisfied by your coverage;
- the amount for which you are responsible (if any);
- general information about your Appeals rights and for ERISA plans, information regarding the right to bring an action after the Appeals process.

COVERED SERVICES

Dental Utilization Review

Dental utilization review is designed to promote the delivery of cost-effective dental care by encouraging the use of clinically recognized and proven procedures. It is included in your Plan to encourage you and your dentist to utilize your dental benefits in a cost-effective and clinically appropriate and recognized manner. Your right to benefits for Covered Services provided under this Plan is subject to review by licensed dentists who will apply certain policies, guidelines and limitations, including, but not limited to, our coverage/clinical 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 general standards of care for dental practice applying state-specific regulations where necessary. The purpose of dental coverage guidelines is to assist in the interpretation of medical or dental necessity. In order to be expenses or services covered under this Plan, such expenses and services must meet Anthem's Medical or Dental Necessity requirements.

Pretreatment Estimate
(Estimate of Benefits)

IT IS RECOMMENDED, BUT NOT REQUIRED, THAT A PRETREATMENT ESTIMATE BE SUBMITTED TO ANTHEM PRIOR TO TREATMENT IF YOUR DENTAL TREATMENT INVOLVES MAJOR RESTORATIVE, ENDODONTIC, PERIODONTAL, ORAL SURGERY, PROSTHETICS, OR ORTHODONTIC CARE (SEE DESCRIPTION OF COVERAGES), TO ESTIMATE THE MAXIMUM ALLOWED AMOUNT. THE PRETREATMENT ESTIMATE IS A VALUABLE TOOL FOR BOTH THE DENTIST AND YOU. SUBMITTING A PRETREATMENT ESTIMATE ALLOWS THE DENTIST AND YOU TO KNOW WHAT BENEFITS ARE AVAILABLE TO YOU BEFORE BEGINNING TREATMENT. THE PRETREATMENT ESTIMATE WILL OUTLINE YOUR RESPONSIBILITY TO THE DENTIST WITH REGARD TO COINSURANCE, DEDUCTIBLES, COPAYS AND NON-COVERED SERVICES. THIS WILL ALLOW THE DENTIST AND YOU TO MAKE ANY NECESSARY FINANCIAL ARRANGEMENTS BEFORE TREATMENT BEGINS. THIS PROCESS DOES NOT PRIOR AUTHORIZE THE TREATMENT NOR DETERMINE ITS DENTAL OR MEDICAL NECESSITY. THE ESTIMATED MAXIMUM ALLOWED AMOUNT IS BASED ON YOUR CURRENT ELIGIBILITY AND CONTRACT BENEFITS IN EFFECT AT THE TIME OF THE COMPLETED SERVICE. SUBMISSION OF OTHER CLAIMS OR CHANGES IN ELIGIBILITY OR THE CONTRACT MAY ALTER FINAL PAYMENT. THIS IS NOT A GUARANTEE OF BENEFITS.

After the examination, your Dentist will establish the dental treatment to be performed. If the dental treatment necessary involves major restorative, endodontics, periodontal, oral surgery, prosthetic services or orthodontic care, you should submit a claim form to Anthem outlining the proposed treatment. Anthem will determine if the proposed treatment is covered and estimate the Maximum Allowed Amount, including your responsibility for Coinsurance, Deductibles, and non-covered services.

A statement will be sent to you and your Dentist estimating the amount of the Maximum Allowed Amount, including the amount that you will owe. These estimates will be subject to your continuing eligibility and the Group Contract remaining in effect. If claims for other completed Dental Services are received and processed prior to the completion date of the proposed treatment, this may reduce Anthem's estimated Maximum Allowed Amount for the proposed treatment and increase your obligation to the Dentist.

TO AVOID ANY MISUNDERSTANDING OF THE MAXIMUM ALLOWED AMOUNT OR THE AMOUNT THAT YOU WILL OWE, ASK YOUR DENTIST ABOUT HIS OR HER PARTICIPATION STATUS AND IF HE OR SHE HAS AGREED TO SERVICE THIS DENTAL PROGRAM PRIOR TO RECEIVING DENTAL CARE.

You will be responsible for payment of any Deductibles, Copays and Coinsurance amounts and any dental treatment that is not considered a Covered Service under your Certificate.

The Plan covers the following Dental Procedures when they are performed by a licensed Dentist and when necessary and customary as determined by the standards of generally accepted dental practice. The benefits under this Certificate shall be provided whether the Dental Procedures are performed by a duly licensed physician or a duly licensed Dentist, if otherwise covered under this Certificate, provided that such Dental Procedures can be lawfully performed within the scope of a duly licensed Dentist.

As a condition precedent to the approval of claim payments, the Plan shall be entitled to request and receive, to such extent as may be lawful, from any attending or examining Dentist, or from hospitals in which a Dentist's care is provided, such information and records relating to a Member as may be required to pay claims. Also, the Plan may require that a Member be examined by a dental consultant retained by Anthem in or near the Member's place of residence. Anthem and the Plan shall hold such information and records confidential.

Anthem does not determine whether a service submitted for payment or benefit under this Certificate is a Dental Procedure that is dentally or medically necessary to treat a specific condition or restore dentition for an individual. The Plan evaluates Dental Procedures submitted to determine if the procedure is a covered benefit. Your coverage includes a preset schedule of Dental Services that are eligible for benefit by Anthem. Other Dental Services may be recommended or prescribed by your Dentist which are dentally or medically necessary, offer you an enhanced cosmetic appearance, or are more frequent than covered by Anthem. While these services may be prescribed by your Dentist and are dentally or medically necessary for you, they may not be a Dental Service that is benefited by Anthem or they may be a service where Anthem provides a payment allowance for a service that is considered to be optional treatment. If Anthem gives you a payment allowance for optional treatment that is covered, you may apply this Anthem payment to the service prescribed by your Dentist which you elected to receive. Services that are not covered by Anthem or exceed the frequency of plan benefits do not imply that the service is or is not dentally or medically necessary to treat your specific dental condition. You are responsible for Dental Services that are not covered or benefited by Anthem. Determination of services necessary to meet your individual dental needs is between you and your Dentist.

Retrospective Review

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

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

If you disagree with a utilization review decision and wish to file an appeal or appeal a decision previously made, you will find details on how to do this in the CLAIM AND APPEAL PROCEDURES section of this certificate. You may also contact customer service at the toll-free number on your identification card.

The utilization review process is governed by laws and regulations and may be modified from time to time by us as those laws and regulations may require.

ONLY those services listed below are covered. Deductibles and Dental Benefit Maximums are listed under the Summary of Benefits. Covered Services are subject to the limitations within the Benefits, Exclusions and Limitations sections described below. For estimates of Covered Services, please see the "Pretreatment Estimate" section of this Certificate.

PREVENTIVE CARE
(Diagnostic & Preventive Services)

Periodic, Comprehensive and Periodontal Oral Evaluations – Any type of evaluation (checkup or exam) is covered 2 times per 12-month period.

NOTE: Comprehensive oral evaluations will be benefited 1 time per dental office, subject to the 2 times per 12-month period limitation. Any additional comprehensive oral evaluations performed by the same dental office will be benefited as a periodic oral evaluation and will be subject to the 2 times per 12-month period limitation.

Limited, Detailed/Extensive and Problem Focused Evaluations – are covered 2 times per 12-month period.

Radiographs (X-rays)

- **Bitewings** – Covered at 1 series of bitewings per 12-month period.
- **Full Mouth (Complete Series) or Panoramic** – Covered 1 time per 60-month period.
- **Periapical(s)** – 4 single x-rays are covered per 12-month period.
- **Occlusal** – Covered at 2 series per 12-month period.

Dental Cleaning

- **Prophylaxis -** Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

  LIMITATION: Any combination of this procedure, Periodontal Maintenance, Scaling in the Presence of Moderate or Severe Gingival Inflammation or Full Mouth Debridement (see Periodontal Services section for the frequency of these services) is covered 2 times per 12-month period.

  NOTE: A prophylaxis performed on a Member under the age of 14 will be benefited as a child prophylaxis. A prophylaxis performed on a Member age 14 or older will be benefited as an adult prophylaxis.

Fluoride Treatment

- Topical application of fluoride and fluoride varnish – Covered 1 time per 12-month period for Dependent children through the age of 18.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered 1 time 60-month period for permanent first and second molars of eligible Dependent children through the age of 18.

EXCLUSIONS – Coverage is NOT provided for:

1. Oral hygiene instructions, including guidance regarding home care. Some examples of oral hygiene instructions includes instructions or guidance on tooth brushing technique, flossing, and/or use of special oral hygiene aids.
2. Amalgam or composite restorations placed for preventive purposes.

Basic Restorative Services

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Amalgam (silver) Restorations – Treatment to restore decayed or fractured permanent or primary teeth.

Composite (white) Resin Restorations

- **Anterior (front) Teeth** - Treatment to restore decayed or fractured permanent or primary anterior (front) teeth.
- **Posterior (back) Teeth** - Treatment to restore decayed or fractured permanent or primary posterior (back) teeth.

LIMITATION: Coverage for amalgam or composite restorations shall be limited to only 1 service per tooth surface per 24-month period.

Basic Extractions

- Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Space Maintainers – Covered 1 time per lifetime on eligible Dependent children through the age of 18 for extracted primary posterior (back) teeth.

LIMITATION: Repair or replacement of lost/broken appliances are not a covered benefit.

Brush Biopsy - Covered 1 time every 12 months.

Consultations - Covered 1 time per 12 month period.

Pin Retention – Covered 1 time per 84-month period.

EXCLUSIONS – Coverage is NOT provided for:

1. Case presentation of detailed treatment plans and office visits, during and after regularly scheduled hours, when no other services are performed.
2. Athletic mouthguard, enamel microabrasion, and odontoplasty.
3. Tooth whitening agents and tooth bonding.
4. Placement or removal of sedative filling, base or liner used under a restoration.
5. Pulp vitality tests.
6. Diagnostic casts.
7. Secondary diagnostic tests in addition to the primary therapy.
8. Amalgam or composite restorations placed for preventive purposes.
9. Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.
10. Analgesia, analgesia agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care.

Endodontic Services (Nerve or Pulp Treatment)

Non-Surgical Endodontic Services

Endodontic Therapy on Primary Teeth

- **Pulpal Therapy** – Covered 1 time per tooth per lifetime.
- **Therapeutic Pulpotomy** – Covered 1 time per tooth per lifetime.

Endodontic Therapy on Permanent Teeth

- **Root Canal Therapy** – Covered 1 time per tooth per lifetime.
- **Root Canal Retreatment** – Covered 1 time per tooth per lifetime.

Endodontic Therapy on Primary or Permanent Teeth

- **Pulp Capping** – Covered 1 time per tooth per lifetime.

Surgical Endodontics

Apicoectomy – Covered 1 time per tooth per 1 lifetime.

Retrograde Filling – Covered.

Root amputation – Covered.

Hemisection – Covered 1 time per tooth per lifetime.

Apexification – Covered 1 time per tooth per lifetime.

EXCLUSIONS - Coverage is NOT provided for:

1. Retreatment of endodontic services that have been previously benefited under the Certificate.
2. Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
3. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
4. Intentional reimplantation.
5. Pulp vitality tests.
6. Incomplete root canals.

Periodontal Services (Gum & Bone Treatment)

Non-Surgical Periodontal Services

Periodontal Maintenance - A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed previous surgical or nonsurgical periodontal treatment.

LIMITATION: Any combination of this procedure, and dental cleanings (see Diagnostic and Preventive section), Full Mouth Debridement and Scaling in the Presence of Moderate or Severe

Gingival Inflammation is covered 4 times per 12-month period.

Scaling in the Presence of Moderate or Severe Gingival Inflammation – Scaling in the Presence of Moderate or Severe Gingival Inflammation is a procedure to remove plaque, tartar and calculus when there is moderate or severe gum inflammation.

LIMITATION: Any combination of this procedure, dental cleanings (see Diagnostic and Preventive section), Periodontal Maintenance and Full Mouth Debridement is covered 2 times per 12-month period.

Basic Non-Surgical Periodontal Care - Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- **Periodontal scaling & root planing** – Covered 1 time per 24 months if the tooth has a pocket depth of 4 millimeters or greater or if the tooth shows demonstrable radiographic evidence of bone loss.

- **Full mouth debridement**

  LIMITATION: Any combination of this procedure, dental cleanings (see Diagnostic and Preventive section), Periodontal Maintenance and Scaling in the Presence of Moderate or Severe Gingival Inflammation is covered 1 time per lifetime.

Chemotherapeutic Agents - Covered 1 time per 12-month period.

Surgical Periodontal Services

All surgical periodontal services are covered on natural teeth only. Surgical periodontal services are denied when performed in conjunction with implants, extractions, ridge augmentation and periradicular surgery services.

Surgical Periodontal Care - Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services under this Certificate.

- **Gingivectomy/gingivoplasty**
- **Gingival flap**
- **Osseous surgery**
- **Bone replacement graft**

LIMITATION: Any 1 or a combination of the above services may be performed 1 time per 36-month period. Complex surgical periodontal service is a benefit covered only if the pocket depth of the tooth is 5 millimeters or greater.

Apically positioned flap – Covered 1 time per tooth per 36-month period.

Guided Tissue Regeneration – Covered 1 time per tooth per 36-month period.

Pedicle soft tissue graft – Covered 1 time per tooth per 36-month period.

Free soft tissue graft – Covered 1 time per tooth per 36-month period.

Connective tissue graft – Covered 1 time per tooth per 36-month period.

Soft tissue allograft – Covered 1 time per tooth per 36-month period.

Distal/proximal wedge – Covered 1 time per tooth per 36-month period.

Crown Lengthening

EXCLUSIONS – Coverage is NOT provided for:

1. Bacteriologic tests for determination of periodontal disease or pathologic agents.

2. Provisional splinting, temporary procedures or interim stabilization of teeth.

3. Analgesia, analgesic agents, anxiolysis, inhalation of nitrous oxide or therapeutic drug injections, drugs, or medicaments for non-surgical and surgical periodontal care, regardless of the method of administration.

Oral Surgery Services (Tooth, Tissue, or Bone Removal)

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Other Complex Surgical Procedures – Complex Oral Surgery includes surgical procedures that involve flap development with the removal and replacement of diseased hard and soft tissues of the oral cavity.

- Oroantral fistula closure
- Tooth reimplantation – accidentally evulsed or displaced tooth
- Mobilization of erupted or malpositioned tooth to aid eruption
- Biopsy of oral tissue
- Transseptal fiberotomy
- Alveoloplasty
- Vestibuloplasty
- Excision of lesion or tumor
- Removal of nonodontogenic or odotogenic cyst or tumor
- Removal of exostosis-per site
- Partial ostectomy
- Incision & drainage of abscess
- Surgical reduction of osseous tuberosity
- Surgical reduction of fiberous tuberosity

Frenulectomy (Frenectomy or Frenotomy)

Intravenous Conscious Sedation, IV Sedation and general anesthesia - Covered when performed in conjunction with complex surgical service.

LIMITATIONS

1. Reconstructive Surgery benefits shall be provided for reconstructive surgery when such Dental Procedures are incidental to or follows surgery resulting from injury, illness or other diseases of the involved part, or when such Dental Procedure is performed on a covered Dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, however that such procedures are dental reconstructive surgical procedures.

EXCLUSIONS - Coverage is NOT provided for:

1. Intravenous conscious sedation, IV sedation and general anesthesia when performed with Non-Surgical dental care.

2. Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration.

3. Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.

4. Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants.

5. Inpatient or outpatient hospital expenses.

6. Cytology sample collection – Collection of oral cytology sample via scraping of the oral mucosa.

7. Implant maintenance or repair to an implant or implant abutment.

8. The treatment of Temporomandibular Joint Disorder (TMJ), cleft lip or cleft palate.

Major Restorative Services- (Crowns, Inlays and Onlays)

Gold foil restorations – Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances.

LIMITATION: The patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Services and optional treatment, plus any Deductible and/or Coinsurance for the covered benefit.

Inlays - Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

LIMITATION: If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and optional treatment, plus any Deductible and/or Coinsurance for the Covered Service.

Pre-fabricated Stainless Steel Crown – Covered 1 time per 84-month period.

LIMITATION: Benefits shall be limited to the allowances for prefabricated stainless steel crown. If a prefabricated resin crown is performed, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and optional treatment, plus any Deductible and/or Coinsurance for the Covered Service.

Onlays and/or Permanent Crowns – Covered 1 time per 84-month period per tooth if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth.

LIMITATION: Benefits shall be limited to the same surfaces and allowances for a predominately base metal onlay. If a porcelain or noble metal onlay is performed to restore a tooth, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and optional treatment, plus any Deductible and/or Coinsurance for the Covered Service.

Implant Crowns – See Prosthodontic Services.

Recement Inlay, Onlay and/or Crowns – Covered 1 time per 12-months. Covered 6 months after initial placement.

Crown, Inlay, Onlay and Veneer Repair – Covered 1 time per 12-months. Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface – Covered 1 time per 84-month period when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Occlusal Guard - Covered 1 time per 24-month period.

Veneers - Covered 1 time per 84-month period.

EXCLUSIONS – Coverage is NOT provided for:

1. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
2. Placement or removal of sedative filling, base or liner used under a restoration.
3. Canal prep & fitting of preformed dowel & post.
4. Temporary, provisional or interim crown.
5. Onlays or permanent crowns when the tooth does not have decay or fracture.

Prosthodontic Services- (Dentures, Partials, and Bridges)

Tissue Conditioning – Covered 1 time per 24-month period.

Recement Fixed Prosthetic – Covered 1 time per 12 months.

Reline and Rebase – Covered 1 time per 24-month period:

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) – Covered 1 time per 12-month period:

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Denture Adjustments – Covered 2 times per 12-month period:

- when the denture is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the denture.

Partial and Bridge Adjustments – Covered 2 times per 12-month period:

- when the partial or bridge is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) – Covered 1 time per 84-month period:

- if 84 months have elapsed since the last benefited removable prosthetic appliance (denture or partial) and the existing denture or partial needs replacement because it cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) – Covered 1 time per 84-month period:

- if none of the individual units of the bridge has been benefited previously as a crown or cast restoration in the last 84 months; and
- if 84 months have elapsed since the last benefited removable prosthetic appliance (bridge) and the existing bridge needs replacement because it cannot be repaired or adjusted.

LIMITATION: If there are multiple missing teeth, a removable partial denture may be the benefit since it would be the least costly, commonly performed course of treatment. Please refer to the Optional Treatment Plans section. The optional benefit is subject to all contract limitations on the Covered Service.

LIMITATION: Benefits shall be limited to the same surfaces and allowances for a base metal restoration. If a porcelain or noble metal restoration is performed to restore a tooth, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and optional treatment, plus any Deductible and/or Coinsurance for the Covered Service.

Single Tooth Implant Body, Abutment and Crown – Covered 1 time per 84-month period. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

LIMITATION: Some adjunctive implant services may not be covered. It is recommended that a Pretreatment Estimate be requested to estimate the amount of payment prior to beginning treatment.

LIMITATION: Benefits shall be limited to the same surfaces and allowances for a predominately base metal crown. If a porcelain or high noble metal crown is placed on the implant, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and optional treatment, plus any Deductible and/or Coinsurance for the Covered Service.

Implant Repair – Covered 1 time per 12-month period. Covered only after 6 months following initial placement of the implant.

Cone Beam Imaging - Covered 1 time per 60 months. Covered only in conjunction with implant covered services.

EXCLUSIONS – Coverage is NOT provided for:

1. The replacement of an existing partial denture with a bridge.

2. Initial installation of an implant(s), full or partial dentures or fixed bridgework to replace a tooth (teeth) which was extracted prior to becoming a Member under this Certificate. EXCEPTION: This exclusion shall not apply for any person who has been continuously covered under this Certificate for more 24 months.
3. Coverage for congenitally missing teeth. EXCEPTION: This exclusion shall not apply for any person who has been continuously covered under this Certificate for more than 24 months.
4. Interim removable or fixed prosthetic appliances (dentures, partials or bridges).
5. Additional, elective or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments.
6. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
7. Placement or removal of sedative filling, base or liner used under a restoration.

Coverage shall be limited to the least expensive professionally acceptable treatment

Orthodontics – Treatment necessary for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies.

Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.

Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.

Comprehensive (complete) Treatment - Full treatment includes all records, appliances and visits.

Removable Appliance Therapy – An appliance that is removable and not cemented or bonded to the teeth. Covered for members through the age of 18.

Fixed Appliance Therapy – A component that is cemented or bonded to the teeth for members through the age of 18.

Cephalometric film

Oral/Facial Images

Other Complex Surgical Procedures

- **Surgical exposure of impacted or unerupted tooth for orthodontic reasons**
- **Surgical repositioning of teeth**

LIMITATION: Orthodontic benefits will be limited to services received after the Member's effective date under this Certificate.

LIMITATION: Covered eligible Dependent children from the age of birth through the age of 18.

Orthodontic Payments: Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. The Member must have continuous eligibility under the Certificate in order to receive ongoing orthodontic benefit payments.

Benefit payments are made in equal amounts: (1) when treatment begins (appliances are installed), and

(2) at six month intervals thereafter, until treatment is completed or until the lifetime maximum benefits are exhausted (see Benefit Maximums in the Summary of Benefits).

Before treatment begins, the treating Dentist should submit a Pre-treatment Estimate. An Estimate of Benefits form will be sent to you and your Dentist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the Dentist should submit the Estimate of Benefit form with the date of placement and his/her signature. After benefit and eligibility verification by the Plan, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be issued to you and your Dentist. This again will serve as the claim form to be submitted 6 months from the date of appliance placement.

Enhanced benefit for Members. Enhanced dental benefits are available for any member diagnosed with the following conditions:

- Cancer with chemotherapy
- Head and neck cancer with chemotherapy and/or radiation
- Solid organ transplant
- Heart disease
- Diabetes
- Pregnancy
- Stroke
- Kidney failure/dialysis
- Suppressed Immune System (HIV)

A member who is pregnant or diagnosed with gestational diabetes is eligible for the additional benefits for a maximum of two Coverage Years. A member diagnosed with the other conditions, are eligible for the additional benefits each Coverage Year until their coverage with the Plan terminates.

To obtain the additional benefit(s), the Member must complete the enhanced benefit application enrollment form and submit it to Us at P.O. Box 9062, Oxnard, CA 93036. The enhanced benefit(s) will be available on the first of the month following the date We receive the enhanced benefit enrollment form.

The following grid identifies and explains how your enhanced benefits will be administered:

Anthem Whole Health Connection								
	Periodontal Maintenance[1]	Periodontal Scaling and Root planing[2]	Periodontal & Oral Evaluations[3]	Routine Cleaning[4]	Palliative Treatment[5]	Fluoride[6]	Sealants[7]	Full Mouth Debridement[8]
Diabetes	√	√	√	√	√			√
Heart Disease	√	√	√	√	√			√
Pregnancy	√	√	√	√	√	√	√	√
Stroke	√	√	√	√	√			√
Kidney Failure/Dialysis	√	√	√	√	√	√	√	√
Head and Neck Cancer w/ Chemo/ Radiation	√	√	√	√	√	√	√	√
Cancers (with chemo)	√	√	√	√	√	√	√	√
Solid Organ Transplant	√	√	√	√	√	√	√	√
Suppressed Immune System (HIV)	√	√	√	√	√			√

[1]Covered at standard frequency

[2]One additional scaling & root planing procedure per quadrant

[3]One additional oral evaluation

[4]One additional routine cleaning; frequency shared with periodontal maintenance

[5]Covered at standard frequency

[6]Removes age limits and provides one additional fluoride treatment

[7]Removes age limits

[8]Covered at standard frequency

Plan provides 100% coverage for qualified benefits and additional frequencies noted regardless of annual maximum/deductible in conjunction with qualified medical conditions.

Enhanced benefit for Members who are enrolled in the Anthem Care Management program. Enhanced dental benefits are available for any member enrolled in the Anthem Care Management program who is in active management with an Anthem Care Manager for the following conditions:

- Cancer with chemotherapy
- Head and neck cancer with chemotherapy and/or radiation
- Solid organ transplant
- Heart disease
- Diabetes
- Pregnancy
- Stroke
- Kidney failure/dialysis
- Suppressed Immune System (HIV)

The following grid identifies and explains how your enhanced benefits will be administered:

Anthem Whole Health Connection								
	Periodontal Maintenance[1]	Periodontal Scaling and Root planing[2]	Periodontal & Oral Evaluations[3]	Routine Cleaning[4]	Palliative Treatment[5]	Fluoride[6]	Sealants[7]	Full Mouth Debridement[8]
Diabetes	√	√	√	√	√			√
Heart Disease	√	√	√	√	√			√
Pregnancy	√	√	√	√	√	√	√	√
Stroke	√	√	√	√	√			√
Kidney Failure/Dialysis	√	√	√	√	√	√	√	√
Head and Neck Cancer w/ Chemo/ Radiation	√	√	√	√	√	√	√	√
Cancers (with chemo)	√	√	√	√	√	√	√	√
Solid Organ Transplant	√	√	√	√	√	√	√	√
Suppressed Immune System (HIV)	√	√	√	√	√			√
[1]Covered at standard frequency				[2]One additional scaling & root planing procedure per quadrant				
[3]One additional oral evaluation				[4]One additional routine cleaning; frequency shared with periodontal maintenance				
[5]Covered at standard frequency								
[7]Removes age limits				[6]Removes age limits and provides one additional fluoride treatment				
				[8]Covered at standard frequency				
Plan provides 100% coverage for qualified benefits and additional frequencies noted regardless of annual maximum/deductible in conjunction with qualified medical conditions.								

EXCLUSIONS

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.

Coverage is NOT provided for:

a) Dental Services that have been paid under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. Benefits under this Certificate will not be reduced or denied because Dental Services are rendered to a Subscriber or Dependent who is eligible for or receiving Medical Assistance.

b) Dental Services or health care services not specifically listed in the Covered Services section of this Certificate (including any hospital charges, prescription drug charges and Dental Services or supplies that do not have an American Dental Association Dental Procedure Code).

c) Services provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist.

d) Dental Services completed prior to the date the Member became eligible for coverage.

e) Services of anesthesiologists.

f) Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a Dentist or an employee of the Dentist who is certified in their profession to provide anesthesia services.

g) Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

h) Dental Services performed other than by a licensed Dentist, licensed physician, his or her employees.

i) Dental Services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

j) Tooth whitening agents and tooth bonding.

k) Orthodontic treatment services, unless specified in this Certificate as a covered Dental Service benefit.

l) Case presentations of detailed treatment plans, office visits during and after regularly scheduled hours, when no other services are performed.

m) A permanent appliance or restoration (such as a partial, denture, bridge or crown) that has not been permanently cemented.

n) Initial installation of an implant(s), full or partial dentures or fixed bridgework to replace a tooth (teeth) which was extracted prior to becoming a Member under this Certificate. EXCEPTION: This exclusion shall not apply for any person who has been continuously covered under this Certificate for more 24 months.

o) Corrections of congenital conditions during the first 24 months of continuous coverage under this Certificate.

p) Athletic mouth guards, enamel microabrasion and odontoplasty.

q) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the Certificate.

r) Bacteriologic tests.

s) Separate services billed when they are an inherent component of a Dental Service.

t) Interim or temporary removable or fixed prosthetic appliances (dentures, partials or bridges).

u) Services for the replacement of an existing partial denture with a bridge.

v) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.

w) Provisional splinting, temporary procedures or interim stabilization.

x) Placement or removal of sedative filling, base or liner used under a restoration.

y) Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.

z) Oral hygiene instruction, including guidance regarding home care. Some examples of oral hygiene instructions includes instructions or guidance on tooth brushing technique, flossing, and/or use of special oral hygiene aids.

aa) Any charges which exceed the Maximum Allowed Amount.

bb) Implant maintenance or repair to an implant or implant abutment.

cc) Pulp vitality tests

dd) Secondary diagnostic tests in addition to the primary therapy.

ee) Diagnostic casts

ff) Incomplete root canals

gg) Anatomical crown exposure.

hh) Temporary anchorage devices.

ii) Amalgam or composite restorations placed for preventive or cosmetic purposes.

jj) Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.

kk) The treatment of Temporomandibular Joint Disorder (TMJ), cleft lip or cleft palate.

Limitations

a) Optional Treatment Plans: in all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Member and the Dentist; however, if more than one treatment plan would be considered for a dental condition, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Member.

b) Reconstructive Surgery: benefits shall be provided for reconstructive surgery when such Dental Procedure is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part, or when such Dental Procedure is performed on a covered Dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, however that such services are dental reconstructive surgical services.

c) Some procedures are an integral part of another completed service covered by the Certificate. If the Dentist bills these procedures separately from the covered service, the Plan will disallow coverage for the separately billed procedures. You will then be responsible for any charge for the separately billed procedures and must pay your Dentist directly.

Optional Treatment Plans

In all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Member and the Dentist; however, if more than one treatment plan would be considered for a dental condition, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Member.

GENERAL PROVISIONS

Entire Contract; Changes
This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

Time Limit on Certain Defenses
After two years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for the policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of the two-year period.

Grace Period
A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force (subject to the right of the insurer to cancel in accordance with the cancellation provision hereof).

Reinstatement
If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with the reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Physical Examination
The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim where it is not forbidden by law.

Legal Actions
No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of claim has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of claim is required to be furnished.

Change of Beneficiary
Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this Certificate or to any change of beneficiary of beneficiaries, or to any other changes in this Certificate.

Workers' Compensation Insurance
The Certificate does not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance.

Relationship of Parties (Plan - Participating Dentists)
The relationship between the Plan and Participating Dentists is an independent contractor relationship. Participating Dentists are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Participating Dentists.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Participating Dentist or in any Participating Dentist's facilities.

Your Participating Dentist's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers**,** including Participating Dentists and Non-Participating Dentists. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

Not Liable for Provider Acts or Omissions
The Plan is not responsible for the actual care you receive from any person. This Certificate does not give anyone any claim, right, or cause of action against the Plan based on what a Provider of dental care, services or supplies, does or does not do.

Identification Card
Your Identification Card identifies the dental program in which you are enrolled. When you receive care from a Participating or Non-Participating Dentist, you must show your Identification Card. Possession of an Identification Card confers no right to services or other benefits under this Certificate. To be entitled to such services or benefits you must be a Member on whose behalf all applicable Premiums under this Certificate have been paid. If you receive services or other benefits to which you are not then entitled under the provisions of this Certificate you will be responsible for the actual cost of such services or benefits.

Circumstances Beyond the Control of the Plan
In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of the Plan, disability of a significant part of a Participating Dentist's personnel or similar causes, or the rendering of dental care services provided under this Certificate is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Participating Dentists shall render dental care services provided under this Certificate insofar as practical, and according to their best judgment; but the Plan and Participating Dentists shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Reinstatement of Coverage for Members of the Military
Members of the United States Military Reserve and National Guard who terminate coverage as a result of being ordered to active duty, may have their coverage reinstated without waiting periods or exclusions of coverage for preexisting conditions.

Extension of Benefits
If this Dental Certificate terminates, benefits will be continued for a period of 60 days for the following:

1. The installation of new appliances and modifications to appliances for which a master impression was made prior to the benefit termination date.
2. An installation of a crown, bridge, or cast restoration for which the tooth was prepared prior to the benefit termination date.
3. Root canal therapy, for which the pulp chamber was opened prior to the benefit termination date.
4. Orthodontic treatment which began prior to the benefit termination date.

Extension of Benefits will not apply if the group policy terminates.

Continuation of Care After Termination of a Participating Dentist
Upon the termination of the contract or other agreement with any Participating Dentist, we shall be liable to pay the cost of Covered Services (other than any applicable deductible and coinsurance) rendered by that Participating Dentist to a Member who retains eligibility under this Certificate or by operation of law, and who is under the care of that Participating Dentist at the time of such termination, and that Participating Dentist shall continue to provide such services for treatment in progress to the Member in accordance with the terms of this Certificate, until the treatment in progress is completed, up to a maximum of 180 days unless reasonable and medically appropriate provision is made for the completion of treatment in progress by another Participating Dentist.

Coordination of Benefits
Special coordination of benefits (COB) rules apply when you or members of your family have additional dental care coverage through other dental plans, including another Anthem insurance plan.

All benefits provided under this agreement are subject to this provision. However, benefits will not be increased by this COB provision. This provision applies if the total payment under this agreement absent this provision and under any other contract is greater than the value of Covered Services.

Primary coverage and secondary coverage. When a member is also enrolled in another dental plan, one coverage will pay benefits first (be primary) and the other will pay second (be secondary). The decision of which coverage will be primary or secondary is made using benefit determination rules.

When we provide secondary coverage, we first calculate the amount that would have been payable had we been primary. Then we coordinate benefits so that the combination of the primary plan's payment and our payment does not exceed the amount we would have paid had it been primary.

If there is more than one other insurance plan, this provision will apply separately to each plan. If another plan has a coordination of benefits provision that applies to only part of its services, the terms of this paragraph will be applied separately to that part and to any other part.

Anthem will not determine the existence of any other contract, or the amount of benefits payable under any other contract except this agreement. The payment of benefits under this agreement shall be affected by the benefits payable under other contracts only when Anthem is given information about other contracts.

If the rules of this plan and the other plan both provide that this plan is primary, then this agreement is primary. When Anthem determines that this plan is secondary under the rules described below, benefits will be coordinated so that our payment plus the other plan’s payment will not exceed the Anthem Maximum Allowed Amount for Covered Services.

Order of Benefit Determination Rules

1. If pediatric dental Essential Health Benefits are included as part of your medical plan, the medical plan will be the primary coverage and this dental plan will be secondary.
2. If you have two dental plans, the plan which includes pediatric dental Essential Health Benefits will be the primary coverage.
3. If neither of the above applies, the Order of Benefit Determination Rules below will determine the coordination of benefits.
4. If you are covered under one plan as a primary insured and another plan as a dependent, the plan under which you are the primary insured will be the primary coverage.
5. As required by law, if you or a dependent also has coverage under Medicare, this plan will always be primary.
6. For children who are covered under both parents' plans, the following will apply:
    a. The plan of the parent whose birthday occurs earlier in the calendar year will be primary.
    b. When parents are separated or divorced, the following special rules will apply:
        i. If the parent with custody has not remarried, that parent’s plan will be primary.

ii. If the parent with custody has remarried, that parent's contract will be primary and the stepparent's plan will be secondary. The benefits of the plan of the parent without custody will be determined last.
iii. The rules listed above may be changed by a court decree:
- A court decree that orders one of the parents to be responsible for health care expenses will cause that parent's plan to be primary, but only if the entity providing the benefits in this case is notified of the court decree before applying benefits.
- If the court decree does not state that one of the parents is responsible for health care expenses and both parents have joint custody, the plan of the parent whose birthday occurs earlier in the calendar year will be primary.

7. If the other plan includes the gender rule, then that rule will be used instead of the rules listed above. The gender rule states that the father's plan will be primary for the children.
8. If there are situations not covered above, then the plan that has been in effect the longest period of time (without interruption) will be primary. There is an exception to this rule. The plan that covers a working employee (or his dependent) will be primary. The plan of a laid-off employee, a retired employee, or a person on continuation of coverage options under federal or state law will be secondary.
9. If another plan has different rules from those listed above other than the gender rule, that plan will be primary.

If payments should have been made under this agreement under the rules of this provision, but they have been made under any other plan, Anthem may pay an entity (provider, other carrier, etc.) that has paid any amounts it determines will meet the intent of this provision. These amounts shall be deemed to be benefits paid under this agreement. Upon this payment, Anthem will no longer be liable under this agreement.

Relationship of Parties (Group-Member-Plan)
Neither the Group nor any Member is the agent or representative of the Plan.

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

Conformity with Law
Any provision of this Certificate which is in conflict with the laws of the state in which the Group Dental Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Modifications
This Certificate allows the Group to make the Plan coverage available to eligible Members. However, this Certificate shall be subject to amendment, modification, and termination in accordance with any of its provisions, the Group Dental Contract, or by mutual agreement between the Plan and the Group without the permission or involvement of any Member. Changes will not be effective until 30 days after We provide written notice to the Group about the change. By accepting the Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms, conditions, and provisions in this Certificate.

Right of Recovery
When the amount we paid exceeds our liability under this Certificate, we have the right to recover the excess amount. This amount may be recovered from you, the person to whom payment was made or any other plan. The request for recovery must be made within 365 days of the initial payment.

CLAIM AND APPEAL PROCEDURES

All claims should be submitted within 12 months of the date of service. An initial benefit determination on your claim will be made within 30 days after receipt of your claim. You will receive written notification of this benefit determination. The 30-day period may be extended for an additional 15 days if the claim determination is delayed for reasons beyond our control. In that case, we will notify you prior to the expiration of the initial 30-day period of the circumstances requiring an extension and the date by which we expect to render a decision. If the extension is necessary to obtain additional information from you, the notice will describe the specific information we need, and you will have 45 days from the receipt of the notice to provide the information. Without complete information, your claim will be denied.

Appeals
In the event that we deny a claim in whole or in part, you have a right to a full and fair review. Your request to review a claim must be in writing and submitted within 180 days from the claim denial. We will make a benefit determination within 60 days following receipt of your appeal.

Your appeal must include your name, your identification number, group number, claim number, and dentist's name as shown on the Explanation of Benefits. Send your appeal to:

Anthem Blue Cross Life and Health Insurance Company
Attention: Appeals Unit
PO Box 1122
Minneapolis, MN 55440-1122

You may submit written comments, documents, or other information in support of your appeal. You will also be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the denied or reduced claim (whether or not presented or available at the initial determination) and the initial determination will not be given any weight.

The review will be conducted by someone different from the original decision-makers and without deference to any prior decision. Because all benefit determinations are based on a preset schedule of Dental Services eligible under your plan, claims are not reviewed to determine dental necessity or appropriateness. In all cases where professional judgment is required to determine if a procedure is covered under your plan's schedule of benefits, we will consult with a dental professional who has appropriate training and experience. In such a case, this professional will not be the same individual whose advice was obtained in connection with the initial adverse benefit determination (nor a subordinate of any such individual). In addition, we will identify any dental professional whose advice was obtained on our behalf, without regard to whether the advice was relied upon in making the benefit determination. If, after review, we continue to deny the claim, you will be notified in writing.

Authorized Representative
You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or an appeal. However, no authorization is required for your treating dentist to make a claim or appeal on your behalf. The authorization form must be in writing, signed by you, and include all the information required in our Authorized Representative form. This form is available at our web site or by calling Customer Service Department at (844) 729-1565. You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

CONTACTING CALIFORNIA DEPARTMENT OF INSURANCE

If You have a grievance or complaint against Anthem, including Your ability to access health care in a timely manner, You may contact us to discuss Your concern and/or obtain a grievance form at:

Anthem Blue Cross Life and Health Insurance Company
21555 Oxnard Street

Woodland Hills, CA 91367

If You need help with a grievance involving an emergency, a grievance or complaint that has not been satisfactorily resolved, regarding your ability to access health care in a timely manner, a grievance or an issue that has remained unresolved for more than thirty (30) days, You may contact the Department of Insurance for assistance. They can be reached at:

California Department of Insurance, Consumer Services Division

300 South Spring St., South Tower

Los Angeles, CA 90013

Toll-free phone number: 1-800-927-HELP (4357)

TDD Number: 1-800-482-4TDD (4833)

Anthem's grievance or complaint process and the Department of Insurance's complaint review process are in addition to other dispute resolution procedures that may be available to You and Your failure to use these processes does not preclude Your use of any other remedy provided by law. Additional information of these rights is explained in the section titled BINDING ARBITRATION.

BINDING ARBITRATION

ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT.

It is understood that any dispute including disputes relating to the delivery of services under the plan or any other issues related to the plan, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

YOU AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL OR TO PARTICIPATE IN A CLASS ACTION IS WAIVED FOR BOTH DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND MEDICAL MALPRACTICE CLAIMS.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate shall apply.

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

The arbitration is initiated by the member making a written demand on Anthem Blue Cross Life and Health Insurance Company. The arbitration will be conducted by a single neutral arbitrator from Judicial Arbitration and Mediation Services ("JAMS"), according to JAMS' applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by a single neutral arbitrator from another neutral arbitration entity, by agreement of the Insured and Anthem Blue Cross Life and Health Insurance Company, or by order of the court, if the Insured and Anthem Blue Cross Life and Health Insurance Company cannot agree. If the parties cannot agree on the individual neutral arbitrator, the arbitrator will be selected in accordance with JAMS Rule 15 (or any successor rule).

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. Unless you, and Anthem Blue Cross Life and Health Insurance Company agree otherwise, the arbitrator may not consolidate more than one person's claims, and may not otherwise preside over any form of a representative or class proceeding.

Please send all Binding Arbitration demands in writing to:

Anthem Blue Cross Life and Health Insurance Company
PO Box 1122
Minnealpolis, MN 55440-1122

CALIFORNIA DEPARTMENT OF INSURANCE

If you or any Member covered under this Certificate have a problem regarding your coverage, please contact Anthem Blue Cross Life and Health first to resolve the issue. If contacts between you (the complainant) and Anthem Blue Cross Life and Health Insurance Company (the Insurer) have failed to produce a satisfactory solution to the problem, you may wish to contact the California Department of Insurance. They can be reached at the following address and phone numbers:

Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
(800) 927-HELP (4357)
Out-of-State Caller – (213) 897-8921
Telecommunication Device for the Deaf – (800) 482-4833
Email: “Consumer Services Division” link at www.insurance.ca.gov

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
This notice has important information about your application or benefits. Look for important dates. You might need to take action by certain dates to keep your benefits or manage costs. You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Spanish
Este aviso contiene información importante acerca de su solicitud o sus beneficios. Busque fechas importantes. Podría ser necesario que actúe para ciertas fechas, a fin de mantener sus beneficios o administrar sus costos. Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Arabic
يحتوي هذا الإشعار على معلومات مهمة حول طلبك أو المزايا المقدمة لك. احرص على تتبع المواعيد المهمة. قد تحتاج إلى اتخاذ إجراء قبل مواعيد محددة للاحتفاظ بالمزايا أو لإدارة التكلفة. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. يُرجى الاتصال برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة .(TTY/TDD:711)

Armenian
Այս ծանուցման մեջ ներկայացված են կարևոր տեղեկություններ Ձեր խնդրագրի կամ նպաստների վերաբերյալ: Ուշադրություն դարձրեք այնտեղ նշված ամսաթվերին, դրանք կարևոր են: Հնարավոր է, Ձեզնից պահանջվի կատարել որոշակի գործողություններ, որպեսզի ձեր նպաստները շարունակվեն կամ, որպեսզի վերահսկեք ծախսերը: Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Chinese
本通知有與您的申請或利益相關的重要資訊。請留意重要日期。您可能需要在特定日期前採取行動以維護您的利益或管理費用。您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Farsi
این اطلاعیه حاوی اطلاعات مهم در مورد درخواست یا مزایای شما است. به تاریخهای مهم دقت کنید. ممکن است لازم باشد در برخی تاریخهای خاص اقدامی انجام دهید تا مزایای خود را حفظ کنید یا هزینه‌ها را مدیریت کنید. شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید(TTY/TDD:711).

Hindi
इस सूचना में आपके आवेदन या लाभों के बारे में महत्वपूर्ण जानकारी है। महत्वपूर्ण तिथियाँ देखें। अपने लाभ बनाए रखने या लागत का प्रबंध करने के लिए, आपको निश्चित तिथियों तक कार्रवाई करने की ज़रूरत हो सकती है। आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Hmong
Daim ntawm ceeb toom no muaj lus qhia tseem ceeb ntsig txog koj daim ntawv thov los sis cov txiaj ntsig ntau yam. Nrhiav saib cov vas thib uas tseem ceeb. Tej zaum koj yuav tsum tau ua raws li cov vas thib uas paub tseeb txhawm rau ceev koj cov txiaj ntsig los sis tswj cov nqi. Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Japanese
このお知らせには、あなたの申請または給付金に関する重要な情報が含まれています。重要な日付を探してください。給付金の維持、あるいは費用の管理のために、特定の日までに行動する必要があるかもしれません。この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer
សេចក្តីជូនដំណឹងនេះមានព័ត៌មានសំខាន់អំពីពាក្យសុំ ឬផលប្រយោជន៍របស់អ្នក។ សូមរកមើលកាលបរិច្ឆេទសំខាន់។ អ្នកប្រហែលជាត្រូវចាត់ការឲ្យបានត្រឹមកាលបរិច្ឆេទជាក់លាក់នោះ ដើម្បីរក្សាផលប្រយោជន៍ ឬគ្រប់គ្រងសោហ៊ុយចំណាយរបស់អ្នក។ អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ និងទទួលជំនួយជាភាសាដែលអ្នកប្រើដោយឥតគិតថ្លៃ។ សូមហៅ ទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលជំនួយ។ (TTY/TDD: 711)

Korean
이 공지사항에는 귀하의 신청서 또는 혜택에 대한 중요한 정보가 있습니다. 중요 날짜를 살펴 보십시오. 혜택을 유지하거나 비용을 관리하기 위해 특정 마감일까지 조치를 취해야 할 수 있습니다. 귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Punjabi

ਇਸ ਨੋਟਿਸ ਵਿੱਚ ਤੁਹਾਡੀ ਅਰਜ਼ੀ ਜਾਂ ਫਾਇਦਿਆਂ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੈ। ਮਹੱਤਵਪੂਰਨ ਮਿਤੀਆਂ ਦੇਖੋ। ਤੁਹਾਨੂੰ ਸ਼ਾਇਦ ਆਪਣੇ ਫਾਇਦੇ ਰੱਖਣ ਜਾਂ ਲਾਗਤਾਂ ਦਾ ਪ੍ਰਬੰਧ ਕਰਨ ਲਈ ਨਿਸ਼ਚਿਤ ਮਿਤੀਆਂ ਤੱਕ ਕੋਈ ਕਾਰਵਾਈ ਕਰਨ ਦੀ ਲੋੜ ਪਏ। ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian
Настоящее уведомление содержит важную информацию о вашем заявлении или выплатах. Обратите внимание на контрольные даты. Для сохранения права на получение выплат или помощи с расходами от вас может потребоваться выполнение определенных действий в указанные сроки. Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте.
(TTY/TDD: 711)

Tagalog
May mahalagang impormasyon ang abisong ito tungkol sa inyong aplikasyon o mga benepisyo. Tukuyin ang mahahalagang petsa. Maaaring may kailangan kayong gawin sa ilang partikular na petsa upang mapanatili ang inyong mga benepisyo o mapamahalaan ang mga gastos. May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai
ประกาศนี้มีข้อมูลสำคัญเกี่ยวกับการสมัครสมาชิกหรือสิทธิประโยชน์ของท่าน โปรดดูวันที่ที่สำคัญ ท่านอาจจำเป็นต้องดำเนินการบางอย่างในวันที่ที่ระบุเพื่อรักษาสิทธิประโยชน์และจัดการค่าใช้จ่าย ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ (TTY/TDD: 711)

Vietnamese
Thông báo này có thông tin quan trọng về đơn đang ký hoặc quyền lợi bảo hiểm của quý vị. Hãy tìm các ngày quan trọng. Quý vị có thể cần phải có hành động trước những ngày nhất định để duy trì quyền lợi bảo hiểm hoặc quản lý chi phí của mình. Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ.
(TTY/TDD: 711)

It’s important we treat you fairly

That’s why we follow federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance.

You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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