ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY
DENTAL BLUE ® ENHANCED

If you have any questions regarding your eligibility or membership please feel free to contact us toll free at (800) 333-0912 or you may write to us at Anthem Blue Cross Life and Health Insurance Company, P.O. Box 9051, Oxnard, California 93031-9051.

If you have any questions regarding claims status or your benefits under this Policy, please feel free to contact our dental customer service department toll free at (888) 209-7852 or write to us at Anthem Blue Cross Life and Health Insurance Company, P.O. Box 9066, Oxnard, CA 93031-9066.

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

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

Leslie A. Margolin
Chief Executive Officer
Anthem Blue Cross Life and Health
Insurance Company

Kathy L. Kiefer
Secretary
Anthem Blue Cross Life and Health
Insurance Company

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

Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association. ®Anthem is a registered trademark. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Dental Blue® is a registered mark of the Blue Cross Blue Shield Association.

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DENTAL BLUE ENHANCED

ISSUED BY

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

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

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

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

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

In this Policy, "We", "us," "our", mean Anthem Blue Cross Life and Health Insurance Company ("Anthem Blue Cross Life and Health," "Anthem"). In this Policy, "you," "your" and "Insured" mean the Policyholder named on the enrollment application, and any eligible Dependents who were listed on the enrollment application and which were accepted by us for coverage under this Policy.

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

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

If, within two (2) years after the Effective Date of this Policy, We discover any material facts that were omitted or that you knew, but did not disclose on your application, We may rescind this Policy as of the original Effective Date. Additionally, if within two (2) years after adding additional family members (excluding Newborn children of the Insured added within 31 days after birth), We discover any material facts that were omitted or that you knew, but did not disclose in your application, We may rescind coverage for the additional family member as of the date he or she originally became effective.

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

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

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

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

IMPORTANT!

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

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

PART 1 HOW TO USE YOUR DENTAL PLAN

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

Using Your ID Card

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

Choosing a Dentist

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS DENTAL SERVICES MAY BE OBTAINED AND COVERED. PLEASE REFER TO THE DENTAL BENEFIT SECTION OF THIS POLICY FOR BENEFIT DETAILS.

You do not have to select a particular Dentist to receive dental benefits. You have the freedom to choose the Dentist you want to utilize to access Covered Services. However, your provider choice (Participating Dentist (Dental Blue 100, Dental Blue 200, Dental Blue 300) or Non-Participating Dentist) can make a difference in the amount you pay.

Participating Dentists. We have established a network of various types of Participating Dentists. These Dentists are called "Participating Dentists" because they have agreed to participate in Our contracted Preferred Provider Organization (PPO) network(s). They have agreed to provide you with dental care at a Negotiated Rate.

There are three PPO network choices: Dental Blue 100, Dental Blue 200, and Dental Blue 300.

- Dental Blue 100 Participating Dentists have signed an agreement with Us to accept the Dental Blue 100 Negotiated Rate as payment in full for Covered Services. You will normally receive the greatest level of benefits available for Covered Services under this Plan when you seek treatment from a Dental Blue 100 Participating Dentist.

- Dental Blue 200 and 300 Participating Dentists have signed an agreement with Us to provide Covered Services to Dental Blue 100 Members at a reduced rate. If you choose to receive treatment from a Dental Blue 200 or Dental Blue 300 Participating Dentist, you will be responsible for any difference between the Dental Blue 100 Negotiated Rate and the Dental Blue 200 or Dental Blue 300 Negotiated Rate. This additional amount is called protected balance billing.

To find a **Participating Dentist**, please access our web site at www.anthem.com/ca or call our Customer Service Department at (888) 209-7852.

Non-Participating Dentists. Non-Participating Dentists are providers who have not agreed to participate in our preferred provider organization network. They have not agreed to the Negotiated Rates and other provisions of a preferred provider organization network contract. The amount of benefits payable under this plan will be different for Non-Participating Dentists than for Participating Dentists.

Making an appointment with the Dentist

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

How To Submit a Claim

Participating Dentists will submit your claims to us. However, if you go to a Non-Participating Dentist either you or your Dentist must claim benefits by sending us properly completed claim forms itemizing the services or supplies received and the charges. Claim forms that you submit must be received by us within fifteen (15) months from the date the services or supplies are received. Although claim forms are preferred, other acceptable documentation such as speed bills can be submitted. Anthem shall provide claim forms upon request. You can request claim forms by calling us toll free at (888) 209-7852, or by writing to us. Notice given by or on behalf of the policyholder or the beneficiary to Anthem, or to any authorized agent of Anthem, with information sufficient to identify the policyholder, shall be deemed notice to Anthem.

After we receive a written notice of claim, we will give you any forms you need to file proof of loss. If claims forms are not furnished within 15 days upon request, the policyholder 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. Use the following address to request claim forms or to send your completed claims forms or other acceptable documentation such as speed bills:

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

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

PART 2 WHAT YOU SHOULD KNOW ABOUT YOUR COVERAGE

Who is Eligible for Coverage

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

Dependents: Any of the following persons listed on the enrollment application completed by the Policyholder and who is insurable according to our applicable underwriting requirements.

- The Policyholder's lawful spouse.

- The Policyholder's Domestic Partner, subject to the following:

  The Policyholder and Domestic Partner have completed and filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code. The Domestic Partner does not include any person who is covered as a Policyholder or spouse.

- Any children of the Policyholder, the Policyholder's enrolled spouse or enrolled Domestic Partner who are under age 19.

- Any unmarried children of the Policyholder, the Policyholder's enrolled spouse or enrolled Domestic Partner who are between their 19th and 23rd birthday, provided they are dependent upon them for at least half of their support and/or a full time student (for 12 or more units or credits) in a properly accredited secondary or post-secondary educational or vocational institution (a college, university or trade or technical school). If your Dependent does not continue to meet the qualifications to remain as a Dependent on your Policy, but is a resident of California, We will automatically offer your Dependent, the same Policy under his/her own identification number.

- Dependents of the Policyholder, the Policyholder's enrolled spouse or enrolled Domestic Partner's children who are over 23 years of age who: continue to be both incapable of self –sustaining employment due to continued physically or mentally disabling injury, illness, or condition and are dependent upon the Policyholder, enrolled spouse or enrolled Domestic Partner for support.

  Ninety (90) days before the dependent child reaches 23 years of age, Anthem Blue Cross Life and Health will issue a request for proof that the child continues to meet the criteria for continued coverage. The Policyholder must submit written proof that the child meets such criteria within sixty (60) days of receiving the request. Before the date the child reaches the age of 23, Anthem Blue Cross Life and Health will determine whether the dependent child meets the criteria for continued coverage. Two (2) years after receipt of the initial proof, We may require no more than annual proof of the continuing handicap and dependency.

  Anthem Blue Cross Life and Health may request a new Policyholder to provide information regarding a dependent child with a continued physically or mentally disabling injury, illness or condition at the time of enrollment and not more than annually thereafter for proof that the child meets the criteria for continued coverage. The Policyholder must submit written proof of such dependency within sixty (60) days of receiving the request.

- Dependents who are unmarried children of the Policyholder, the Policyholder's enrolled spouse or Domestic Partner who are between their 19th and 23rd birthday and are full-time students may retain coverage while they are on a medical leave of absence from school. The dependent child's coverage shall not terminate for a period not to exceed 12 months or until the date on which the coverage is scheduled to terminate as indicated in this Policy, whichever comes first. The period of coverage under this paragraph shall commence on the first day of the medical leave of absence from school or on the date the physician determines the illness prevented the dependent child from attending school, whichever comes first. Any break in the school calendar shall not disqualify the dependent child from coverage under this paragraph. Documentation or certification of the medical necessity for a leave of absence from school shall be submitted to Anthem Blue Cross Life and Health at least 30 days prior to the medical

leave of absence from school, if the medical reason for the absence and the absence are foreseeable, or 30 days after the start date of the medical leave of absence from school if the medial reason for the absence and the absence are not foreseeable and shall be considered evidence of entitlement to coverage under this paragraph.

- Newborns of the Policyholder, the Policyholder's enrolled spouse or enrolled Domestic Partner for the first thirty-one (31) days of life. TO CONTINUE COVERAGE, THE NEWBORN MUST BE ENROLLED AS A DEPENDENT BY NOTIFYING US IN WRITING WITHIN SIXTY (60) DAYS OF BIRTH AND THE POLICYHOLDER WILL BE RESPONSIBLE FOR ANY ADDITIONAL PREMIUMS DUE EFFECTIVE FROM THE DATE OF BIRTH.

  NEWBORNS OF THE POLICYHOLDER'S DEPENDENT CHILDREN **ARE NOT** covered under this Policy.

- A child being adopted by the Policyholder will have coverage for up to thirty-one (31) days from the date on which the adoptive child's birth parent or appropriate legal authority signs a written document granting the Policyholder, enrolled spouse or enrolled Domestic Partner the right to control health care for the adoptive child, or absent this document, the date on which other evidence exists of this right. TO CONTINUE COVERAGE, THE ADOPTED CHILD MUST BE ENROLLED AS A DEPENDENT BY NOTIFYING US IN WRITING WITHIN SIXTY (60) DAYS OF THE DATE THE POLICYHOLDER'S AUTHORITY TO CONTROL THE CHILD'S HEALTH CARE IS GRANTED AND THE POLICYHOLDER WILL BE RESPONSIBLE FOR ANY ADDITIONAL PREMIUMS DUE EFFECTIVE FROM THE DATE THE POLICYHOLDER'S AUTHORITY TO CONTROL THE CHILD'S HEALTH CARE IS GRANTED.

Your Effective Date

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

Monthly Premiums

Premiums are the monthly charges the Policyholder must pay Anthem to establish and maintain coverage. Anthem determines and establishes the required premiums based on the Policyholder's age and the specific regional area in which the Policyholder resides. If the Policyholder changes residence, he or she may be subject to a change in premiums, without prior written notice from Anthem. Such change in premiums will be effective on the next billing date following Anthem's receipt of written notification of the change of residence. If the Policyholder does not notify Anthem of a change in residence and Anthem later learns of the change in residential address, Anthem may in its discretion bill the Policyholder for the difference in premium from the date the address changed. Anthem is not required to notify the Policyholder of a premium increase when a Policyholder, on his or her Anniversary date, enters into a new age bracket. Anthem will recalculate your premium based upon the age of the Policyholder on your Policy Anniversary Date and your premium will be automatically adjusted to the new rate prior to any other premium change, Anthem will send out written notification 30 days in advance of such change.

There are several billing options available:

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

YOU WILL BE RESPONSIBLE FOR AN ADDITIONAL $25 CHARGE FOR ANY CHECK OR DEBIT WHICH IS RETURNED OR DISHONORED BY THE BANK AS NON-PAYABLE TO US FOR ANY REASON. You will also be responsible for a $15 manual processing fee if you call customer service to make your premium payment. This fee is waived if you choose to set up a recurring payment option. The fee would also be waived if you choose Auto Pay Interactive Voice Response (IVR). This fee would also be waived if you were unable to use the Auto Pay IVR.

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

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

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

If We do not receive your written request at least thirty (30) days in advance of your premium due date, We will not be able to make the requested change in time to coincide with your premium due date. Just call us at (800) 333-0912.

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

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

Duration of your Policy

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

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

3. Although your Policy expires at the end of each billing cycle, it will, upon timely payment of the billed premiums, automatically renew under the same terms and conditions unless (1) We have terminated, canceled, or declined to renew the Policy pursuant to the section entitled HOW YOUR COVERAGE ENDS; or (2) We have modified the Policy pursuant to the section entitled NOTICE TO CANCEL OR CEASE COVERAGE AND OUR RIGHT TO MODIFY YOUR POLICY below. In the case of a modification under the section entitled NOTICE TO CANCEL OR CEASE COVERAGE AND OUR RIGHT TO MODIFY YOUR POLICY, the Policy will renew for the term specified in Paragraph 2. above under the modified terms and conditions.

How Your Coverage Ends

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

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

fifteen (15) days after We issue the Notice of Cancellation. You are not entitled to a grace period until you have made your first payment to us. If you need covered benefits during the grace period, coverage will be provided. However, We will deduct the premiums due for coverage continued during the grace period from any benefits We pay.

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

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

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

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

6. Upon becoming ineligible for this coverage. See the section called WHEN AN INSURED BECOMES INELIGIBLE FOR COVERAGE.

When An Insured Becomes Ineligible For Coverage

An Insured becomes ineligible for coverage under this Policy when:

1. The Policyholder does not pay the premiums when due, subject to the grace period.
2. The spouse is no longer married to the Policyholder.
3. The Domestic Partnership has terminated and the Domestic Partner no longer satisfies all eligibility requirements specified for Domestic Partners.
4. The child fails to meet the eligibility rules listed in the section entitled WHO IS ELIGIBLE FOR COVERAGE.
5. The Insured becomes enrolled under any other Anthem Blue Cross Life and Health Insurance Company non-group dental Policy.

Notice Of Change In Eligibility

You must notify us of all changes affecting any Insured's eligibility under this Policy except for the first and last paragraphs listed above, under **How Your Coverage Ends**.

Options In The Event Of Changed Circumstances

Dependents who lose eligibility for coverage under this Policy may apply for their own coverage.

If your Dependent does not meet the qualifications to remain as a Dependent on your Policy, We will automatically enroll your Dependent, if a resident of California, on the same Policy under his/her own identification number.

The written application must be submitted to us within thirty-one (31) days of the loss of eligibility in order to avoid having to provide proof of good health.

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

1. Before We will cease to provide any new or existing individual dental benefit Policy:
   a. We will give you at least 180 days written notice prior to cessation of this Policy, and

b. Those individual dental benefit Policies that are in effect shall not be canceled for 180 days, after the day of notification to cease coverage, except for specific non-compliance previously stated under the section **How Your Coverage Ends** in this PART.

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

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

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

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

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

      (ii) if We find out about any fraud or deception in the use of the benefits of this Policy by you, your enrolled family or any Insured of your family know about it.

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

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

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

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

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

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

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

Anthem Blue Cross Life and Health Insurance Company

P.O. Box 9066

Oxnard, California 93031-9066

PART 3 WHAT IS COVERED

A. DEDUCTIBLE

Deductible is the amount of charges you will pay before We begin to pay for certain Covered Services. During each Year, each Insured is responsible for all expense incurred up to the Deductible amount.

1. Your yearly Deductible for Covered Services excluding orthodontic services, is $50.00per Insured. The first three Insureds of an enrolled family to satisfy their Deductible in full will satisfy the Deductible for the entire family. Once the family Deductible is satisfied, no further Deductible is required for the remainder of that Year. However, We will not credit any Deductible over and above the family Deductible maximum that was applied but did not satisfy an individual Insured's Deductible amount in full. During each Year, each Insured is responsible for all expense incurred up to the Deductible amount. Only Covered Expense counts toward the Deductible so amounts over Covered Expense a Non-Participating Dentist may charge you won't count. **The Deductible does not apply to diagnostic and preventive services when performed by a Participating Dentist**.

2. Your yearly Deductible for orthodontic benefits is $100.00 per Insured.

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

B. MAXIMUM BENEFITS

Dental benefits are limited to a maximum payment of $1250.00 for expense incurred by each Insured during a Year.

Orthodontic benefits are limited to a maximum payment of $500.00 per year and $1000.00 per lifetime.

C. BENEFIT WAITING PERIODS

There is no Benefit Waiting Period for preventive and diagnostic services.

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

An Insured must be enrolled for 12 months under this Policy to be eligible for benefits for major dental care services.

An Insured must be enrolled for 12 months under this Policy to be eligible for benefits for orthodontic services.

D. PAYMENT

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY SO YOU WILL KNOW HOW COVERED DENTAL CARE WILL BE REIMBURSED.

Participating Dentists. We will pay benefits at the Participating Dentist payment rate if Covered Services are provided by a Participating Dentist. You have an incentive under this Plan to seek treatment from a Dental Blue 100 Participating Dentist. If you choose to receive services from a Dental Blue 200 or a Dental Blue 300 Participating Dentist, you will incur additional charges over and above your Deductible and Coinsurance amounts. These additional charges are the difference between the Dental Blue 100 Negotiated Rates and the Dental Blue 200 or Dental Blue 300 Negotiated Rates. This difference is called "protected balance billing". Protected balance billing is a plan feature that limits out-of-pocket expenses should you choose to receive Covered Services from a Dental Blue 200 or a Dental Blue 300 Participating Dentist or if you receive a non-Covered Service from a Participating Dentist.

- Covered Services. If you receive Covered Services from a Dental Blue 200 or a Dental Blue 300 Participating Dentist, the Dentist can bill you for the difference between the Dental Blue 100 Negotiated Rates and the Dental Blue 200 or Dental Blue 300 Negotiated Rates. Negotiated Rates are typically lower than the Participating Dentist's usual billed charges.

- Non-Covered Services. Participating Dentists have agreed to accept the Negotiated Rate for all services, whether the services are covered or not. If a Participating Dentist provides a non-Covered Service to you, you are responsible to pay only for the Negotiated Rate, which is typically lower than the Dentist's usual billed charge.

Please refer to your Identification Card to verify that you are a member of Dental Blue 100. If you are uncertain which Participating Dentists will provide you with the lowest out-of-pocket expense, please contact customer service at the toll-free number indicated on your Identification Card or visit online at www.anthem.com.

Non-Participating Dentists. We will pay benefits at the Non-Participating Dentist payment rate if Covered Services are provided by a Non-Participating Dentist. The protected balance billing feature does **not** apply to services provided by Non-Participating Dentists. A Non-Participating Dentist can charge their usual billed charges for services rendered.

SUMMARY OF COSTS

If you receive treatment from a Dental Blue 100 Participating Dentist:

- Payment rates will be based on the Participating Dentist payment rate.

- You are responsible for any Coinsurance, Deductibles, non-Covered Services, and any amounts over the dental benefit maximums.

If you receive treatment from a Dental Blue 200 or Dental Blue 300 Participating Dentist:

- Payment rates will be based on the Participating Dentist payment rate.

- You are responsible for any Coinsurance, Deductibles, non-Covered Services, and any amounts over the dental benefit maximums PLUS any applicable protected balance billing amounts.

If you receive treatment from a Non-Participating Dentist:

- Payment rates will be based on the non-Participating Dentist payment rate.

- You are responsible for any Coinsurance, Deductibles, non-Covered Services, and any amounts over the dental benefit maximums, PLUS any amount which exceeds the Covered Dental Expense. The protected balance billing feature does not apply.

Payment Rate

At a Participating Dentist, benefits will be paid for Covered Services at the following payment rates:

- 100% of the Covered Expense each Insured incurs for diagnostic and preventive services (Deductible is waived); and
- 80 % of the Covered Expense each Insured incurs in excess of the Deductible for basic dental care services; and
- 50 % of the Covered Expense each Insured in excess of the Deductible for oral surgery services; and
- 50% of the Covered Expense each Insured in excess of the Deductible for endodontic services; and
- 50% of the Covered Expense each Insured in excess of the Deductible for periodontal services; and
- 50 % of the Covered Expense each Insured in excess of the Deductible for prosthodontics; and
- 50% of the Covered Expense each Insured incurs in excess of the Deductible for orthodontic services.

At a Non-Participating Dentist benefits will be paid for Covered Services at the following payment rates:

- 80% of Covered Expense each Insured incurs in excess of the Deductible for diagnostic and preventive services ; and
- 60% of the Covered Expense each Insured incurs in excess of the Deductible for basic dental care services; and
- 50% of the Covered Expense each Insured incurs in excess of the Deductible for oral surgery services; and
- 50% of the Covered Expense each Insured incurs in excess of the Deductible for endodontic services; and
- 50% of the Covered Expense each Insured incurs in excess of the Deductible for periodontal services; and
- 50% of the Covered Expense each Insured incurs in excess of the Deductible for prosthodontics; and
- 50% of Covered Expense each Insured incurs in excess of the Deductible for orthodontic services.

E. DENTAL CONDITIONS OF SERVICE

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

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

F. COVERED SERVICES

This section describes the Covered Services available under your dental benefits when provided and billed by a Dentist. All Covered Services are subject to the terms, limitations and exclusions stated in this Policy, including the yearly Maximum Benefit and dental benefit maximums. The amount payable for Covered Services varies depending on whether you receive your care from a Participating Dentist or a Non-Participating Dentist.

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

Diagnostic and Preventive Services

- Oral Evaluations. Limited to two times per calendar Year in any combination of the following types of evaluations: periodic, limited, oral evaluation for a patient under three years of age, comprehensive,

detailed/extensive, periodontal evaluations and office visits for evaluation.

- Bitewing Radiographs (one set of up to four films). Limited to one series of bitewings per calendar Year.
- Vertical Bitewings (7-8 films). Up to 8 films will be covered in any five year period. Benefits are not payable if performed on the same date of service as a panoramic film or full-mouth radiographs.
- Periapical X-rays. Limited to four single films per calendar Year. Benefits are not payable if performed on the same date of service as a panoramic film or full-mouth radiographs.
- Intraoral Occlusal Film. Limited to two films per calendar Year. Benefits are not payable if performed on the same date of service as a panoramic film or full-mouth radiographs.
- Complete Series (panoramic film or full-mouth radiographs). Limited to once every five. Complete series radiographs include bitewings, and will count as one occurrence for that calendar Year. Nine or more radiographs in any combination of periapical, occlusal, and bitewing radiographs will be considered a complete series.
- Adult Prophylaxis. Limited to a total of two per calendar Year, singly or in combination with periodontal maintenance procedure (see Major Dental Care Services). Allowance includes cleaning, scaling and polishing the teeth.
- Child Prophylaxis. Limited to two per calendar Year for children up to the age of 16. Allowance includes cleaning, scaling and polishing the teeth.
- Fluoride Treatments (topical application). Limited to two per calendar Year for Dependent children up to the age of 19.
- Sealants, for unrestored permanent 1st and 2nd molars. Limited to one application per tooth and one replacement per tooth if replacement is performed at least 36 months after initial application. Covered only for Dependent children up to the age of 16.
- Space Maintainers. Limited to once per quadrant per lifetime for children up to the age of 16. Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes initial prosthesis only and all adjustments within six months of placement.
- Recement Space Maintainers. Covered only after 12 months have passed since initial placement.

Basic Dental Care Services

For services to restore a tooth using a crown, see Major Dental Care Services. The following are covered Basic Dental Care Services under this Policy.

- Palliative (Emergency) Treatment for Dental Pain. Limited to one treatment per calendar Year (not covered when performed in conjunction with other dental treatment or examination).
- Consultations (diagnostic service provided by a Dentist other than practitioner providing treatment). Limited to once per calendar Year.
- Amalgam Restorations. Limited to once per year per surface up to age 19 and once per surface every 3 years age 19 and over. Replacement allowed no more than once every 36 months. Multiple surfaces billed on the same tooth for the same date of service are combined and paid as one restoration.
- Composite Resin Restorations. Limited to once per year per surface up to age 19 and once per surface every 3 years age 19 and over. Replacement of existing restoration is allowed no more than once every 36 months. Benefits for composite resin restorations on posterior permanent teeth and primary teeth will be based on the allowance for the corresponding amalgam restoration. Multiple surfaces billed on the same tooth for the same date of service are combined and paid as one restoration.
- Resin based-composite crown (anterior). Limited to once per tooth in any five years.

- Pin Retention. Limited to once per tooth in any 7 years.
- General anesthesia and intravenous (IV) sedation, when used in conjunction with covered oral surgical procedures if Medically Necessary.

Major Dental Care Services

Oral Surgery Services (Tooth, Tissue or Bone Removal)

- Extraction of coronal remnants, primary tooth
- Extraction, erupted tooth or exposed root
- Surgical removal of erupted tooth
- Removal of impacted tooth, soft tissue, partially bony, and completely bony
- Surgical removal of residual tooth roots
- Oral antral fistula closure
- Primary closure of sinus perforation
- Surgical exposure of impacted or unerupted tooth for orthodontic reasons
- Mobilization of erupted tooth to aid eruption
- Removal of lateral exostosis
- Removal of torus, palatinus and mandibularis
- Surgical reduction of osseous tuberosity
- Alveoloplasty (Limited to once per quadrant per lifetime.)
- Vestibuloplasty
- Biopsy of oral tissue, hard and soft
- Frenulectomy, frenuloplasty
- Excision of hyperplastic tissue
- Excision of pericoronal gingiva
- Surgical incision and drainage

Endodontic Services (Nerve or Pulp Treatment)

- Root Canal Therapy. Coverage for root canal therapy includes a treatment plan, clinical procedures, postoperative radiographs, and follow-up care. If multiple endodontic treatments are necessary on the same tooth within a period of one year, the allowance will be made for only one procedure. Root canal therapy is limited to one initial treatment per tooth per lifetime and one retreatment per tooth per lifetime. Coverage is for permanent teeth only.
- Apicoectomy/periradicular services. Covered Expense for apicoectomy/periradicular services includes reimbursement for the removal of granulation tissue at the apex of the tooth. No additional benefit is available for the removal of granulation tissue at the apex of the tooth if billed separately from the apicoectomy/periadicular service. Limited to a lifetime maximum of once per tooth/root.
- Retrograde filling. Limited to a lifetime maximum of once per tooth/root.
- Therapeutic pulpotomy (excluding final restoration). Coverage is for primary teeth only. Limited to a lifetime maximum of once per tooth/root.
- Pulp capping, direct and indirect. Coverage is for primary teeth only. Limited to a lifetime maximum of once per tooth/root.
- Gross pulpal debridement. Not payable if performed in conjunction with root canal treatment or palliative emergency treatment. Limited to a lifetime maximum of once per tooth/root.

Periodontic Services (Gum and Bone Treatment)

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

- Gingivectomy or gingivoplasty. When performed in conjunction with a crown build-up, post and core, or with a crown, the gingivectomy or gingivoplasty is considered part of that procedure and there will be no additional benefit.
- Gingival flap procedure (includes root planing).
- Apically positioned flap.

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

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

- Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis (removal of subgingival and/or supragingival plaque and calculus). Limited to once per lifetime.
- Periodontal scaling and root planing. Limited to once per quadrant every 24 months.
- Periodontal maintenance procedure. Covered only when following active periodontal therapy. Limited to two procedures per calendar Year, singly or in combination with routine prophylaxis.

Prosthodontics- Crowns, Inlays, Onlays

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

- Post and core buildups. Limited to once per tooth in any seven year period, after root canal therapy.
- Crown/onlay repairs. Limited to once per crown/onlay in any seven year period.
- Prefabricated or Stainless steel crowns (for primary teeth only). Once per tooth in any five years.

Prosthodontics, Removable- Dentures and Partials

- Removable complete (immediate or permanent), and partial dentures, but only if the tooth/teeth being replaced were extracted after the Insured's Effective Date. Limited to once in seven years. Benefits are available for the replacement of complete or partial dentures, but only if the prosthesis is seven years old or older and cannot be made serviceable. Benefits are payable for either complete or immediate dentures, but not both. Coverage for these services includes routine post-delivery care and all adjustments within the first 6 months after initial placement. Services are covered for Insureds age 16 and over.
- Denture adjustments. Limited to once per calendar year per denture.
- Denture repairs. Limited to once per denture in a five year period.
- Addition of tooth or clasp. Limited to a lifetime maximum of one tooth addition and 2 clasp additions per denture.
- Replace all teeth and acrylic on partial denture. Limited to once per arch in any five year period.
- Denture rebase and reline procedures. Limited to once per calendar Year for chairside reline and once in three years for laboratory rebase or reline.
- Tissue conditioning. Limited to 2 treatments per arch in any 12-month period.

Prosthodontics, Fixed (Bridges)

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

Fixed Bridges are covered only when:

- The bridge is replacing teeth that were extracted after the Insured's Effective Date; and
- The total units required to replace all missing teeth is six units or less in an arch (arch means maxilla or mandible); and
- The bridge or bridges consist of no more than 6 units total in an arch. (Each abutment is a unit and each pontic is a unit in a bridge). Coverage for fixed bridgework that includes more than a total of 6 units is limited to the amount this Policy would pay for a removable partial denture.

- Recementing a bridge. Limited to a lifetime maximum of once per bridge.
- Post and core. Limited to once per tooth in a seven year period, after root canal therapy.
- Core buildup. Limited to once per tooth in a seven year period.
- Bridge repair. Limited to once per bridge in a seven year period.

Orthodontic Services

Orthodontia is limited to one course of treatment per lifetime for dependent children under age 19 when initial bands are placed. Covered Services include examination records, tooth guidance, and repositioning (straightening) of the teeth, as listed below.

Orthodontic benefits are paid on a quarterly basis and payment is made over the course of treatment, up to the maximum lifetime orthodontic benefit.

For each eligible Insured, after the Deductible is met, the Plan pays the applicable payment rate shown in the "Payment Rate" section for the following orthodontic services:

- Diagnostic orthodontic records (cephalometric film, diagnostic casts), limited to a lifetime maximum of once per eligible Insured.
- Limited Orthodontic Treatment.
- Interceptive Orthodontic Treatment, primary or transitional dentition.
- Comprehensive Orthodontic Treatment, transitional or permanent dentition.
- Minor treatment to control harmful habits.
- Orthodontic Retention. Limited to a lifetime maximum of one Appliance per eligible insured
- Repair of orthodontic appliance.

PART 4 WHAT IS NOT COVERED

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

A. Services not specifically listed in the "Covered Services" section of this Policy.

B. Procedures which are not generally accepted standards of dental practice within the Organized Dental Community in California.

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

D. Any services you actually received that were provided by a local, state, county or federal government agency including any foreign government, except when payment under this Policy is expressly required by federal or state law. This Policy will not cover payment for these services if you are not required to pay for them or they are given to you for free. Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.

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

F. Any services for treatment of injuries sustained or illnesses resulting from participation in a riot or civil disturbance, or while committing or attempting to commit an assault or felony (unless otherwise required by law). Services, treatments or other care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs.

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

H. Expenses Before Coverage Begins or After Coverage Ends: Services received before your Effective Date or services received after your coverage ends.

I. Professional services received from a person who lives in the Insured's home or who is related to the Insured by blood, marriage or adoption.

J. Cosmetic Dentistry: Services provided by dentists solely for the purpose of improving the appearance when tooth structure and function are satisfactory and no pathologic conditions (decay) exist (including but not limited to external bleaching, bleaching of non-vital discolored teeth, composite restorations, veneers, crowns on teeth not exhibiting pathology and facings on crowns on posterior teeth).

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

L. Procedures requiring Appliances, restorations (other than those for replacement of structure loss from tooth decay) that are necessary to alter, restore or maintain occlusions. These include but are not limited to:
- Changing the vertical dimension.
- Replacing or stabilizing lost tooth structure by attrition, abrasion, abfraction, erosion or bruxism.
- Realignment of teeth.
- Gnathological recording.
- Occlusal equilibration.
- Periodontal splinting.

M. Harmful Habit Appliances: Fixed and removable Appliances including but not limited to Appliances to inhibit thumbsucking.

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

O. Replacement of crowns, inlays, onlays and laboratory-fabricated restorations if replacement occurs within seven years of the original placement. Benefits will not be provided for a pontic or an abutment if a fixed or removable partial, crown, or onlay was placed on the affected tooth/teeth in the last seven years.

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

Q. Charges for any duplicate prosthetic device or Appliance, or for a “spare” set of dentures or any other duplicate Appliance such as, but not limited to, removable orthodontic retainers.

R. Prescribed drugs, pre-medication or analgesia including charges for nitrous oxide or any similar local anesthetic when the charge is made separately from a Covered Service.

S. Replacement of existing fillings for any purpose other than restoring tooth structure.

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

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

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

W. Diagnosis or Treatment of the Joint of the Jaw and/or Occlusion: Services, supplies or Appliances provided in connection with: any treatment to alter, correct, fix, improve, remove, replace, reposition, restore or otherwise treat the joint of the jaw (temporomandibular joint) or associated musculature, nerves and other tissues for any reason or by any means.

X. Treatment of congenital or developmental malformations including but not limited to cleft palate, maxillary and mandibular malformations, enamel hypoplasia, fluorosis, and anodontia.

Y. Osseous grafts if the following procedures have been performed on the affected tooth or site on the same date of service or within the previous 12 months:
- Apicoectomy
- Retrograde filling
- Root canal therapy

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

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

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

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

DD. Denture adjustments, repairs, reline and rebase are not covered for a period of six months from initial placement if the denture(s) were paid for under this Policy.

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

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

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

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

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

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

KK. Services or treatments that are not Medically Necessary. Medically Necessary services or treatments are those which are ordered by the attending Dentist for the direct care and treatment of a covered condition.

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

MM. Charges for missed or cancelled appointments.

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

OO. Services for treatment of malignancies and neoplasms.

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

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

Orthodontic Care That Is Not Covered:

A. Myofunctional therapy and related services. (Myofunctional therapy involves the use of muscle exercises as an adjunct to orthodontic mechanical correction of malocclusion.)

B. Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, or correction of micrognathia or macrognathia.

C. Orthodontic services provided before or after the term of your coverage. Orthodontic treatment begun prior to your Effective Date or after the termination of your coverage.

D. TMJ or Hormonal Imbalance Orthodontic Services. Orthodontic treatment related to temporomandibular joint disturbances (TMJ) and/or hormonal imbalance.

E. Orthodontic re-treatment.

PART 5 IMPORTANT INFORMATION ABOUT YOUR PLAN

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

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

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

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

RELATIONSHIP OF PARTIES: We are not responsible for any claim for damages or injuries suffered by the Insured while receiving care in any Hospital, Skilled Nursing Facility, or Dentist's office. Such facilities act as independent contractors.

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

SUBMISSION OF CLAIMS/PROOF OF LOSS: Either the Policyholder or provider of service must claim benefits by sending us properly completed claim forms or other acceptable documentation such as speed bills itemizing the services or supplies received and the charges. These claim forms or other acceptable documentation must be received by us within 15 months of the date services or supplies are received. Otherwise, we will not be liable for the benefits. .

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

TERMS OF COVERAGE:

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

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

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

Receipt of Information: We are entitled to receive from any provider of service information about you that Anthem believes is reasonably necessary to administer claims on your behalf. This right 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 insurablity.

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

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

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

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

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

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

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

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

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 on or after January 1, 2007, may have their coverage reinstated without waiting periods or exclusion of coverage for preexisting conditions. Please contact customer service toll free at 1-800-333-0912 for information on how to apply for reinstatement of coverage following active duty as a reservist.

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

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

PART 6 IF YOU HAVE A COMPLAINT

COMPLAINTS

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

Anthem Blue Cross Life and Health Insurance Company
P.O. Box 9155
Oxnard, California 93031-9066

If you have any questions regarding your eligibility or membership, please contact us toll free at (800) 333-0912, or you may write to us at:

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

DEPARTMENT OF INSURANCE

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

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

BINDING ARBITRATION

This Binding Arbitration provision does not apply to class actions:

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

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

The Insured and Anthem Blue Cross Life and Health agree to be bound by the arbitration provision and acknowledge that they are giving up their right to trial by court or jury for both medical malpractice claims and any other disputes arising under this policy.

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

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

Should damages claimed be $50,000 or less, the arbitration shall be held by a single, neutral arbitrator mutually agreed to by the parties. Such arbitrator shall have no jurisdiction to award more than $50,000. The arbitrator shall be selected in accordance with the applicable rules of the arbitration administration entity. With respect to an arbitration held in California, if the parties are unable to agree on the selection of an arbitrator using the rules of the arbitration administration entity, the method provided in Code of Civil Procedure Section 1281.6 shall be used.

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

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.

Please send all Binding Arbitration demands in writing to:

Anthem Blue Cross Life and Health Insurance Company

P.O. Box 9155

Oxnard, CA 93031-9086

PART 7 NON-DUPLICATION OF ANTHEM BLUE CROSS LIFE AND HEALTH BENEFITS

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

- You will be entitled only to the benefits of the policy with the greater benefits, and

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

PART 8 IMPORTANT TERMS TO KNOW

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

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

B. **Appliance** is a dental device designed to perform a therapeutic or corrective function.

C. **Benefit Waiting Period** the period of continuous coverage under this Policy 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 Periods indicated in the PART called WHAT IS COVERED.

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

E. **Coinsurance** - A percentage of the Covered Dental Expense 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.

F. **Covered Expense** (Covered Dental Expense) - The dollar amount allowed by the Plan for Covered Services. The maximum Covered Expense shall be no more than:
   - For all Participating Dentists, Our Dental Blue 100 Participating Dentist's Negotiated Rate; or
   - For all Non-Participating Dentists, the Covered Expense is the lesser of the Dentist's actual charge or the Dental Blue 100 Negotiated Rate.

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

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

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

J. **Dependents** are members of the Policyholder's family who are eligible and accepted under this Policy.

K. **Domestic Partner** meets this Policy's eligibility requirements for Domestic Partners as outlined in the PART called WHAT YOU SHOULD KNOW ABOUT YOUR COVERAGE.

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

M. **Insured** means both the Policyholder and all other Dependents who are enrolled for coverage under this Policy.

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

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

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

For these purposes "generally accepted standards of dental practice" means standards that are based on credible scientific evidence published in peer-reviewed dental literature generally recognized by the Organized Dental Community in California.

P. **Negotiated Rate** is the rate of payment Participating Dentist agree to accept as payment in full for Covered Services. It is usually lower than their normal charge. Negotiated Rates are determined by preferred provider organization (PPO) Participating Dentist agreements.

Q. **Newborn** is a recently born infant within thirty-one (31) days of birth.

R. **Non-Participating Dentist** is a Dentist who has not entered into a contractual agreement or is not otherwise engaged by us, or with another organization which has an agreement with us, to provide Covered Services and certain administrative functions for one or more of the following three PPO networks: Dental Blue 100, Dental Blue 200, and/or Dental Blue 300.

S. **Organized Dental Community –** Dentists licensed by the California Board of Dental Examiners.

T. **Participating Dentist** is a Dentist who has entered into a contractual agreement or is otherwise engaged by us, or with another organization which has an agreement with us, to provide Covered Services and certain administrative functions for one or more of the following three PPO networks: Dental Blue 100, Dental Blue 200, and/or Dental Blue 300. A directory of Participating Dentists is available on our website at www.anthem.com/ca, or you may call us at the customer service number listed on your identification card.

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

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

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

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