Anthem Dental

Combined Evidence of Coverage and Disclosure Form

Anthem Family Dental PPO

High (83-87%) Actuarial Value

This Evidence of Coverage (EOC) contains the exact terms and conditions of coverage. Please read the disclosure and the EOC completely and carefully. Individuals with special dental care needs should carefully read those sections that apply to them.

Anthem Blue Cross
[P.O. Box 1115
Minneapolis, MN 55440-1115]
[1 (877) 567-1804]

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente. [**Translation note to Department:** If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the customer service number.]

INDSADP-ONHIX 0117

Introduction

Welcome to Anthem Dental

This booklet is your Evidence of Coverage for your Anthem Dental plan. It tells you what is covered and what is not covered under your dental plan with us. You have a right to review this Evidence of Coverage prior to enrollment. You may obtain a copy by requesting it from us in writing at [Anthem Blue Cross, PO Box 1115, Minneapolis, MN 55440-1115], or by calling [1 (877) 567-1804].

Within this booklet, members are referred to as "you" or "your". Anthem Blue Cross is referred to as "we", "us" or "our". All italicized words are defined in the Definitions section of this booklet.

A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

How to Contact Us

We are here to help you. Call us if:

- You have a question or problem regarding your Anthem Dental plan.
- You need to find a dentist.
- You need to replace your dental ID card.

☎ [1 (877) 567-1804]
✉ [Anthem Blue Cross, P.O. Box 1115, Minneapolis, MN 55440-1115]
[www.anthem.com/ca]

When you visit our website, click on the "Health and Wellness" link for information on dental care and more.

Language and Communication Assistance

Anthem introduced its Language Assistance Program to provide certain written translation and oral interpretation services to California Members with limited English proficiency. The Language Assistance Program makes it possible for you to access oral interpretation services and certain written materials vital to understanding your health coverage at no additional cost to you. Written materials available for translation include grievance and appeal letters, consent forms, claim denial letters, and explanations of benefits. [These materials are available in the following languages:

- [Spanish]
- [Chinese]
- [Vietnamese]
- [Korean]
- [Tagalog]]

Oral interpretation services are available in additional languages.

Requesting a written or oral translation is easy. Just contact us by calling the number from the How to Contact Us section above or at the number on your Identification Card to update your language preference, to receive future translated documents, or to request interpretation assistance. Anthem also sends/receives TDD/TTY messages at [(866) 333-4823] or by using the National Relay Service through 711. A special operator will get in touch with us to help with your needs. For more information about the Language Assistance Program visit [www.anthem.com/ca].

Benefit Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. YOUR EVIDENCE OF COVERAGE SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

If you have any questions about your Anthem Dental plan, call us at [1 (877) 567-1804].

Summary of Dental Benefits

Deductible. The deductible is the amount you must pay before we begin to pay for *covered services*. Each individual member is responsible to meet their deductible. You have to meet your deductible every *coverage year* before we will pay for *covered services*.

Individual Pediatric Deductible (per member through age 18)..... $65
Individual Adult Deductible (per member age 19 and older)..... $50

Family Deductible. The family deductible is met when two or more pediatric *members* meet the individual pediatric deductible. Once the family deductible is met, no other *members* through age 18 will be responsible to meet their individual pediatric deductible.

Family Deductible (two or more members through age 18)..... $130

NOTE: Deductibles do not apply to Diagnostic and Preventive Services.

Waiting Periods. A waiting period is the length of time you must be covered under this *plan* before we pay benefits. Certain types of services may have waiting periods under your *plan*. You are eligible for benefits once you meet your waiting periods.

Type of Service	*Waiting Period*
The following waiting periods apply to members age 19 and older	
Diagnostic and Preventive Services	none
Basic Restorative Services	none
Endodontic Services	6 months
Periodontal Services	6 months
Oral Surgery Services	6 months
Major Restorative Services	6 months
Prosthodontic Services	6 months

Annual Out of Pocket Maximum. There is an annual out of pocket maximum in this *plan*. This amount is the most you will pay out of pocket in a *coverage year* for *essential health benefits* before we will pay 100% of the *maximum allowed amount* for *essential health benefits*. Once the individual or family deductible is reached, you must pay your member cost-share, such as any *coinsurance*, until the annual out-of-pocket maximum is reached. Your premium amount, charges for services that are not covered, or charges for services received from a *non-participating dentist* do not apply to the annual out of pocket maximum. If you have coverage under another plan, amounts paid by that plan will not apply to the annual out of pocket maximum, as those amounts were not paid by you.

Annual Out of Pocket Maximum for 1 child..... $350
Annual Out of Pocket Maximum for 2 or more children..... $700

Benefit Maximums. The following benefit maximums are the dollar amount we will pay for *covered services* for each member, subject to the coverage percentages identified below. If you do not reach your annual benefit maximum, any unused amount will not be carried over to the next *coverage year*.

Combined for Participating and Non-Participating Dentists

Coverage Year Maximum (*for members through age 18*)	no limit
Medically Necessary Orthodontic Care Lifetime Benefit Maximum	no limit
Coverage Year Maximum (*for members age 19 and older*)	$1,500

Coverage Percentages

After you have met any applicable *deductibles* or waiting periods, we pay the following percentages of the *maximum allowed amount* for *covered services*. The *maximum allowed amount* is different for *participating* and *non-participating dentists*. If you see a *non-participating dentist*, you may have more out-of-pocket expenses. To learn more about how the *maximum allowed amount* is determined, see the section called Dentists and Claims Payment.

Pediatric Dental Essential Health Benefits

The following benefits are available to *member*s through the end of the month in which they turn 19 years old.

Type of Service	**Participating Dentists**	**Non-Participating Dentists**
Diagnostic & Preventive Services	100%	90%
Basic Restorative Services	80%	70%
Endodontic Services	50%	50%
Periodontal Services	50%	50%
Oral Surgery Services	50%	50%
Major Restorative Services	50%	50%
Prosthodontic Services	50%	50%
Medically Necessary Orthodontic Care	50%	50%

Adult Dental Benefits

The following benefits are available to *member*s age 19 and older only.

Type of Service	**Participating Dentists**	**Non-Participating Dentists**
Diagnostic & Preventive Services	100%	90%
Basic Restorative Services	80%	70%
Endodontic Services	50%	50%
Periodontal Services	50%	50%
Oral Surgery Services	50%	50%
Major Restorative Services	50%	50%
Prosthodontic Services	50%	50%
Orthodontic Services	Not covered	Not covered

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Dentists and Claims Payments

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 choice of *dentist* 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 between a *participating dentist* and a *non-participating dentist*.

IMPORTANT: If you opt to receive dental services that are not *covered services* under this *plan*, a *participating dentist* may charge you their usual and customary rate for those services. Prior to providing a patient with dental services that are not covered, the *dentist* should provide you with a treatment plan that includes each anticipated services to be given, as well as the estimated cost for each service. If you would like more information about your dental coverage options, call customer service at [(877) 567-1804] or your insurance broker. To fully understand your coverage, you should carefully read this entire booklet.

Participating Dentists

Participating dentists are dentists that have signed a written agreement with us to service the plan identified in this *EOC*. *Participating dentists* have agreed to our *maximum allowed amount* as payment in full for a *covered service*. Because *participating dentists* have agreed to accept the *maximum allowed amount* as payment in full for *covered service*s, they should not send you a bill or collect for amounts above the *maximum allowed amount*. You may, however, receive a bill or be asked to pay a portion of the *maximum allowed amount* if you have not met your *deductible*, have a *coinsurance* due, have received non-covered services, or have exceeded any *coverage year maximums* you may have. See the Summary of Dental Benefits for more information on your benefits, your cost shares, and your *coverage year maximums*.

Facilities

Choosing a *participating dentist* will likely result in lower out of pocket costs to you. You may call us if you need help finding a *participating dentist*.

☏ [1 (877) 567-1804]

Or a complete list of *participating dentists* can be found on our website.

[www.anthem.com/ca]

Please refer to your *ID card* for the name of the dental program that participating providers have agreed to service when you are choosing a *participating dentist*.

Non-Participating Dentists

Non-participating dentists are dentists who have NOT signed a written agreement with us to service the plan identified in this *EOC*. *Non-participating dentists* have not agreed to accept our *maximum allowed amount* as payment in full for a *covered service*. For *covered services* you receive from a *non-participating dentist*, we will pay either our *maximum allowed amount* or the dentist's actual charges, whichever is less. The *maximum allowed amount* is based on our non-participating dentist fee schedule, which we reserve the right to modify from time to time after considering one or more of the following:

1. Record fee data;
2. Reimbursement amounts accepted by like/similar providers contracted with us;
3. Reimbursement amounts accepted by like/similar providers for the same services or supplies; or
4. Other industry cost, reimbursement, and utilization data.

Unlike *participating dentists*, a *non-participating dentist* may send you a bill and collect for any amount that exceeds our *maximum allowed amount*. You are responsible for paying the difference between the *maximum allowed amount* and the dentist's charge. This amount may be significant.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your *dentist*. It provides you and the *dentist* with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the *dentist* and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthodontic, endodontic, oral surgery or orthodontic care.

NOTE: The pretreatment estimate is recommended, but it is not required for you to receive benefits for *covered services*.

A pretreatment estimate does not authorize treatment or determine its medical necessity and does not guarantee benefits. The estimate will be based on your current eligibility and the *plan* benefits in effect at the time the estimate is submitted to us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed service(s). Submission of other claims, changes in your eligibility or changes to the *plan* may affect our final payment.

You can ask your *dentist* to submit a pretreatment estimate for you, or you can send it to us yourself. Please include the procedure codes for the services to be performed (your *dentist* can tell you what procedures codes). Pretreatment estimate requests can be sent to the address under the How to Contact Us section earlier in this booklet.

How We Pay Claims

This section describes how we determine the amount of reimbursement for *covered services*. Reimbursement for *covered services* rendered by *participating* and *non-participating dentists* are based on our *maximum allowed amount* for the type of service performed. The *maximum allowed amount* is the maximum amount of reimbursement we will pay for *covered services*. 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*.

We make payments for your dental care only when the *covered services* have been completed. We may require additional information from you or your *dentist* before a claim can be considered complete and ready for processing. In order to properly process a claim, we may be required to add an administrative policy line to the claim. For example, if your *dentist* submits a claim for an adult dental cleaning and it should have been a pediatric dental cleaning, we will correct the clerical error and add a line explaining the correction. Duplicate claims submitted or previously processed will be denied.

When a claim is submitted for your dental care, we will apply processing rules to the claim. These rules evaluate the claim information and, among other things, 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 submit 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 happens, our payment will be based on the *maximum allowed amount* for the single procedure code rather than a separate *maximum allowed amount* for each billed procedure code.

Likewise, when multiple procedures are performed on the same day by the same or different *dentist(s),* we may reduce the *maximum allowed amount* for those additional procedures, because reimbursement at 100% of the *maximum allowed amount* would represent a duplicate payment for a service that may be considered incidental or inclusive.

Payment of Benefits. Usually, we will make payments directly to the *participating dentist* for *covered services* received. However, we also reserve the right to make payments directly to you. Payment, as well as notice regarding the receipt and/or decision of a claim, may also be made to 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.

WHEN SERVICES ARE OBTAINED FROM A NON-PARTICIPATING DENTIST, ANY BENEFITS PAID UNDER THIS PLAN ARE PAID DIRECTLY TO YOU. YOU ARE RESPONSIBLE FOR PAYING THE CHARGES MADE BY A NON-PARTICIPATING DENTIST.

Once a dentist gives a *covered service*, we will not honor a request for us to withhold payment of the submitted claims.

Explanation of Benefits

After you receive dental care, you will often receive an Explanation of Benefits (EOB). The EOB is a summary of the services you received and the coverage you receive under this *plan*. The EOB is not a bill, but a statement from us to help you understand the coverage for your dental care. The EOB shows the following:

- Total amounts charged for the services and/or supplies received;
- The amount of the charges paid by your coverage;
- The amount for which you are responsible (if any); and
- General information about your appeals rights

Making an Appointment

To see your *dentist* you will need to call and make an appointment. When you call, identify yourself as a Anthem Dental member and have the following information from your ID card available:

- Your name
- The ID number on your ID card
- A brief explanation of your symptoms, if any.

Your first visit to your *dentist* will usually consist of x-rays and an examination only. By performing these procedures first, your *dentist* can establish your treatment plan according to your overall dental needs.

If you are not able to keep your appointment, call the dental office as soon as possible to let them know. Your dental office may charge you if you do not cancel your appointment at least 24 hours before your appointment. These charges will not be paid by us. You will be responsible to pay for any charges for missed appointments.

Premiums

Your premium is the monthly charge you must pay us for this coverage. To keep your coverage under this *plan* active, you must pay your premium by the due date on your monthly statements, subject to the grace period..

Your Cost Share

Maximum Allowed Amount, Deductibles, and Coinsurance. For certain *covered services*, depending on your plan, you may be required to pay a portion of the *maximum allowed amount* (for example, a *deductible* and/or *coinsurance*). Your *deductible*, *coinsurance* and out of pocket costs may vary depending on whether you receive dental care from a *participating* or *non-participating dentist*. Specifically, you may pay higher out of pocket costs when using a *non-participating dentist*. Please see the Summary of Dental Benefits for more information on your cost share responsibilities and benefit limitations.

Customer service is also available to answer questions about your plan, as well as assist you in determining the *maximum allowed amount* for a *covered service* from a *non-participating dentist*. In order for us to best assist you, please have the specific dental procedure code for the services the *dentist* will provide. 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, our payment for your dental care will be based on the actual claim submitted.

Your ID Card

Your ID card shows your *dentist* what plan you are on. You will need your ID card each time you see the *dentist*. Keep your ID card with you and present it when asked.

Who is Covered and When

This section tells you who is eligible for coverage under this *plan* and when that coverage begins and ends. Families purchasing this plan must have at least one adult age 18 or older who has also purchased a medical plan that is a Platinum, Gold, Silver or Bronze *qualified health plan* through the Exchange. If a dependent child is enrolled in a family dental plan, all dependent children in the family under age 19 must also be enrolled in the same family dental plan.

Who is Eligible for Coverage

Subscriber. To be eligible for membership as a subscriber under this plan, the applicant must:

1. Be determined by the Exchange to be a *qualified individual* for enrollment in a *qualified health plan (QHP)*.
2. Be a United States citizen or national; or
3. Be a lawfully present non-citizen for the entire period for which coverage is sought; and
4. Be a resident for the State of California; and meet the following applicable residency standards;
    a. For a *qualified individual* age 21 and over, the applicant must:
        i. not be living in an institution
        ii. be capable of indicating intent
        iii. not to be receiving option state supplementary payments (ssp)
    b. For a *qualified individual* under age 21, the applicant must:
        i. not be living in an institution
        ii. not be emancipated
        iii. not be receiving optional state supplementary payments (ssp)
5. Reside in the service area of the Exchange
6. Reveal any coordination of benefits arrangements or other dental benefit arrangements for you or your *dependents* as they become effective.
7. Agree to pay the premiums that Anthem requires;
8. Not be incarcerated (except pending disposition of charges).

For purposes of eligibility, a *qualified individual's* service area is the area in which the *qualified individual*:

1. resides, intends to reside (including without a fixed address);
2. is seeking employment (whether or not currently employed) or
3. has entered without a job commitment.

For *qualified individuals* under age 21, the service area is that of the parent or caretaker with whom the *qualified individual* resides.

For tax households with members in multiple Exchange service areas:

1. All of the members of a tax household are not living within the same Exchange service area, any member of the tax household may enroll in a *QHP* through any of the Exchanges for which one of the tax filers meets the residency requirements.
2. If both spouses in a tax household enroll in a *QHP* through the same Exchange, a tax dependent may only enroll in a *qualified health plan* through that Exchange, or through the Exchange that services the area in which the dependent meets a residency standard.

Dependents. To be covered as a *dependent*, you must be listed on the enrollment form completed by the *subscriber*, be determined by the Exchange to be a *qualified individual*, and meet all *dependent* eligibility criteria. The following *dependents* of a *subscriber* may be covered under this *plan*:

1. Your legal spouse.
2. Your domestic partner, as long as you and your domestic partner are in a legally registered and valid domestic partnership.

Coverage will be provided equally to a spouse or domestic partner. This includes coverage for a spouse or domestic partner's children, as long as eligibility requirements are met. All references to spouse in this *EOC* will include domestic partners.

3. Dependent children up to the age of 26, including:
   a. your and your spouse's natural-born and legally adopted children;
   b. children for whom you or your spouse are the legal guardian;
   c. stepchildren; and
   d. grandchildren who are financially dependent on you and reside with you or your spouse continuously from birth.

4. Disabled children who have reached age 26 if:
   a. they are primarily dependent upon you or your spouse;
   b. they are incapable of self sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability; and
   c. were disabled before they reached age 26.

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

Newborn and Adopted Child Coverage. Your or your spouse's newborn children will be covered for an initial period of 60 days from the date of birth. Coverage for newborns will continue beyond the 60 days, provided you submit a form through the Exchange to add the child under this plan. The form must be submitted along with the additional *premium*, if applicable, within 60 days after the birth of the child.

A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; 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.

Qualified Medical Child Support Order. If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enrollee your child under this policy, and the child is otherwise eligible for the coverage, you must request permission from the Exchange for your child to enroll under this plan, and once approved by the Exchange, we will provide the benefits of this plan in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any *dependent* age limit. Any claims payable under this plan will be paid, at our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to us directly.

Open Enrollment

As established by the rules of the Exchange, *qualified individuals* are only permitted to enroll in a *QHP*, or as an enrollee to change *QHP*s, during the annual open enrollment period or a special enrollment period for which the *qualified individual* has experienced a qualifying event.

An annual open enrollment period is provided for *qualified individuals* and enrollees. *Qualified individuals* may enroll in a *QHP*, and enrollees may change *QHP*s at that time according to rules established by the Exchange.

American Indians are authorized to move from one *QHP* to another *QHP* once per month.

Changes Affecting Eligibility and Special Enrollment. A special enrollment period is a period during which a *qualified individual* or enrollee who experiences certain qualifying events or changes in eligibility may enroll in, or change enrollment in, a *QHP* through the Exchange, outside of the annual open enrolment period.

Length of special enrollment periods: Unless specifically stated otherwise, a *qualified individual* or enrollee has 60 calendar days from the date of a triggering event to select a *QHP*.

The Exchange must allow *qualified individuals* and enrollees to enroll in or change from one *QHP* to another as a result of the following triggering events:

- A *qualified individual* or *dependent* loses his or her Minimum Essential Coverage. The term Minimum Essential Coverage means any of the following: Government sponsored programs; coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a state; coverage under a grandfathered health plan, and such other health benefits coverage, such as a state health benefits risk pool, or as the Secretary of HHS recognizes);
- A *qualified individual* gains a *dependent* or becomes a dependent through marriage, birth, adoption or placement for adoption;
- An individual, not previously a citizen national, or lawfully present gains such status;
- A *qualified individual's* enrollment or non-enrollment in a *QHP* is unintentional, inadvertent, or erroneous and is the result of an error of the Exchange or the Department of Health and Human Services (HHS), or its instrumentalities as determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error;
- An enrollee demonstrates to the Exchange that the *QHP* in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a *QHP*;
- The Exchange must permit individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- A *qualified individual* or enrollee gains access to new *QHP*s as a result of a permanent move; and
- A *qualified individual* or enrollee demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the Exchange may provide.

Effective Date. Your coverage begins on the effective date, which is the first day of the coverage year following your selection made during the Exchange's annual open enrollment period.

Effective dates for special enrollment period:

1. In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption. Advance payments of the premium tax credit are not effective until the first day of the following month in which you provided notice, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and
2. In the case of marriage, or in the case where a *qualified individual* loses his or her Minimum Essential Coverage, coverage is effective on the first day of the following month in which you provided notice.

Notice of Changes in Eligibility. You are responsible to notify the Exchange of any changes that will affect your or your dependents' eligibility under this plan. The Exchange must be notified of changes as soon as possible, but not later than within 60 days of the event. This includes changes in address, marriage, divorce, domestic partnership status, death, and change in number of dependents. Failure to notify the Exchange when you or your dependents are no longer eligible for services will not obligate us to pay for such services. All notifications must be in writing (with all necessary information about the change) and on approved forms, or as otherwise required by the Exchange.

How Coverage Ends

This section will tell you how your coverage ends. Unless otherwise stated, your coverage will end on the last day of the month following the event. We will send notice of cancellation 30 days before your coverage ends. Coverage for *dependents,* if any, will end when your (the *subscriber's*) coverage ends. Your coverage will end in the following situations listed below.

You Tell Us to Cancel Your Coverage. You must notify us in writing that you want to cancel your coverage. If you do not provide a cancellation date, your coverage will end on the first of the month following our receipt of your written notice. If you elect coverage and subsequently cancel this *plan*, you and your *dependent*s, if any, will not be allowed to re-enroll in this coverage for a period of 24 months from the date the coverage was cancelled.

You Tell the Exchange to Cancel Your Coverage. Your coverage will end on a date determined by the Exchange once you provide appropriate notice the Exchange that you want to cancel this coverage. If you elect coverage and subsequently cancel this *plan* you and your *dependent*s, if any, will not be allowed to re-enroll in this coverage for a period of 24 months from the date the coverage was cancelled.

Non-Payment of Premiums. If you do not pay your premium by the end of the grace period, your coverage will be cancelled.

You or your dependent is no longer eligible. If you or a *dependent* no longer meets the eligibility requirements listed in the Who is Eligible for Coverage section, your coverage may be cancelled.

Fraud or Misuse of Benefits. If you or your *dependent* knowingly engages in any fraud or misuse of the benefits of this agreement, your coverage may be cancelled. Coverage will end on the date we send written notice of cancellation.

Fraudulent Misstatements. If you make any fraudulent misstatements on your application, your coverage may be cancelled. We will send written notice of cancellation at least 15 days before your coverage ends.

When a Child's Coverage Ends. Covered children of this *plan* will receive the *pediatric dental essential health benefits* through the end of the month in which they turn age 19. Upon reaching age 19, unless we receive notice to cancel, the covered child will receive benefits under the Adult Dental Benefits of this *plan* until the end of the month in which they reach age 26. Dependent children that are disabled may continue coverage beyond this age. Please see the Who is Eligible section above for more information.

Renewability. This *plan* will continue as long as your *premiums* are paid, subject to the grace period and as long as you are considered a *qualified individual* by the Exchange.

We reserve the right to withdraw this *plan* from the market and terminate the *plan*, by giving you written notice at least 31 days prior to the renewal date. Termination of the *plan* will result in loss of coverage for all *members*. If the *plan* is terminated, the rights of the *members* are limited to *covered services* incurred before termination. Termination is without prejudice to any claim originating while the *plan* was in force.

If you think we should NOT have ended (terminated) your coverage. We cannot end your coverage because of your dental needs or dental condition. If you think that we wrongly ended your coverage, you can file a complaint with us as described in the section Grievance Procedures.

What is Covered

All *covered service*s are subject to the terms, limitations, and exclusions of your *plan*. See the Summary of Dental Benefits for your cost share amounts, such as *deductibles* and/or any *coinsurance*.

Your Dental Benefits. There is a preset schedule of dental care services that are covered under this *plan*. We evaluate the procedures submitted to us on your claim to determine if they are a *covered service* under this *plan*,

Claims for orthodontic care will be reviewed to determine if it was Medically Necessary Orthodontic Care. See the section "Orthodontic Care" for more information.

Your *dentist* may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this *plan*. While these services may be necessary for your dental condition, they may not be covered by us. There may be an alternative dental care service available to you that is covered under your *plan*. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your *dentist*. You are responsible for any costs that exceed the allowance, in addition to any *coinsurance* or *deductible* you may have.

The decision as to what dental care treatment is best for you is solely between you and your *dentist*.

Pediatric Dental Essential Health Benefits

We cover the following dental care services for *member*s through the end of the month in which they turn 19 years old when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, we will cover the least expensive.

These pediatric dental benefits comply with the Pediatric Dental Essential Health Benefit benchmark plan, as chosen by Covered California, including any required coverage in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnoses and Treatment (EPSDT) benefit.

Diagnostic and Preventive Services

Oral Exams.

- periodic oral exam covered 1 per 6 months
- limited oral exam
- comprehensive oral exam
- detailed and extensive oral exam
- limited or problem focused re-evaluations covered 12 per 12 months; covered 6 times per 3 months for temporomandibular joint conditions

Radiographs (X-rays)

- complete series (includes bitewings) covered once per 36 months
- periapicals covered 20 times per 12 months
- occlusal films covered 2 per 6 months
- bitewings (single film) covered once per day
- bitewings (two films) covered once per 6 months
- bitewings (four films) covered one per 6 months for members age 10 and older
- extraoral 2D radiographic image covered once per day
- extraoral posterior radiograph image covered 4 per day
- posterior-anterior or lateral skull and facial bone survey covered 3 per day
- sialography
- panoramic film covered 1 per 36 months

Diagnostic Casts. Covered as part of orthodontic care.

Dental cleaning (prophylaxis). Procedure to remove plaque, tartar (calculus), and stain from teeth. If you have periodontal maintenance (see Basic Restorative Services), that will count as an instance towards the dental cleaning benefit frequency.

- Child dental cleanings (up to age 14) are covered 1 per 6 months.
- Adult dental cleanings are 1 per 12 months and will count as an instance towards the child dental cleaning.

Fluoride Treatment (topical application or fluoride varnish). Covered 1 time per 6 months.

Dental Sealant Treatments. Covered for first, second and third molars only. Covered once per tooth per 36 months.

Space Maintainers. Unilateral space maintainers are covered once per quadrant. Bilateral space maintainers are covered once per arch.

Recement Space Maintainers.

Removal of Space Maintainer. Covered only when performed by a provider that did not initially place the appliance.

Other Oral Pathology Procedures (by report).

Basic Restorative Services

Emergency Treatment (also called palliative treatment). Covered for the temporary relief of pain or infection. Covered once per day.

Fillings (restorations). Amalgam (silver colored) and composite (tooth-colored) fillings are covered under this plan. Fillings on primary teeth are covered once per tooth per 12 months. Fillings on permanent teeth are covered once per 36 months.

Periodontal Maintenance. Periodontal maintenance is covered 4 times per 12 months and only 24 months after scaling and root planing. If you have a dental cleaning (see Diagnostic and Preventive Services), it will count as an instance toward the periodontal maintenance benefit frequency.

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.

Pins and Pin Build-Up. Covered when given with a restoration service, such as a filling.

Sedative Fillings. Covered once per 6 months.

Miscellaneous Services.

- tomographic surveys are covered 2 per 12 months
- house calls are covered once per day
- office visits are covered once per day
- therapeutic drug injections are covered 4 per day
- application of desensitizing medicament covered once per 12 months
- treatment of complications (post surgical) or unusual circumstances are covered once per day and only within 30 days of an extraction

Endodontic Services

Endodontic Therapy. Covered once per tooth on permanent teeth only:

- root canal therapy
- root canal retreatment – covered 12 months after the initial root canal therapy when given by the same provider as the root canal therapy.

Other Endodontic Treatments. Unless noted otherwise, the following services are covered once per tooth.

- apexification
- apicoectomy – covered 90 days after a root canal therapy by the same provider and 24 months after apicoectomy/perirdacular surgery by the same provider
- therapeutic pulpotomy
- gross pulpal debridement
- partial pulpotomy for apexogenesis
- pulpal therapy
- unspecified endodontic procedure, by report

Periodontal Services

Periodontal Scaling and Root Planing. Covered 1 time per quadrant per 24 months. Covered for *members* age 13 and older.

Complex Surgical Periodontal Care.

- gingivectomy/gingivoplasty – covered once per quadrant per 36 months on members age 13 and older
- osseous surgery – covered once per quadrant per 36 months on members age 13 and older
- unspecified periodontal service, by report – covered for members age 13 and older

Oral Surgery Services

Oral surgery services include post-operative care such as exams, removal of stitches, and treatment of post-surgical complications.

Complex Surgical Extractions. Surgical removal of 3rd molars are covered only when symptoms of pathology exists.

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

Other Oral Surgery Procedures. Covered oral surgeries include, but are not limited to:

- biopsies of oral tissues (hard) – covered once per arch per day
- biopsies or oral tissues (soft) – covered 3 per day
- excision of lesions, cysts and tumors
- removal of palatal torus and mandibular torus – covered once per quadrant per lifetime
- frenulectomy (frenectomy or frenotomy) – covered once per arch per day
- incision and drainage of abscesses – covered once per quadrant per day
- oroantral fistula closure
- sinus perforation – primary closure
- sinus augmentation
- surgical reduction of tuberosity – covered once per quadrant per lifetime

- sequestrectomy for osteomyelitis – covered once per quadrant per day and only after 30 days has passed since an extraction
- temporomandibular joint arthrogram (including injection) is covered 3 per day

Intravenous Conscious Sedation, IV Sedation and General Anesthesia. Covered when given with a covered complex surgical service. The service must be given in a dentist's office by the *dentist* or an employee of the *dentist* that is certified in their profession to give anesthesia services. Non-intravenous conscious sedation may be used for members under 13 when they are uncooperative.

Local Anesthesia. Covered only when given with another covered restoration service (such as a filling or crown). Covered once per day.

Nitrous Oxide. Covered for members under 13 when they are uncooperative. Covered only when given in a dental office by a provider that is acting within the scope of their license.

Major Restorative Services

Permanent Crowns. Covered 1 time per 60 months for members age 13 and older. The following types of crowns are covered under this plan:

- resin (lab procedure)
- ¾ resin-based composite (indirect)
- resin with predominantly base metal
- porcelain with ceramic substrate
- porcelain fused to predominately base metal
- ¾ cast predominately base metal
- ¾ porcelain/ceramic
- full cast predominately base metal

Recement Inlay, Onlay, or Partial Coverage Restoration. Covered once per 12 months.

Recement Crown and Crown Repair. Covered 12 months after initial placement of crown. Covered only when given by the same provider that placed the crown.

Restorative Cast Post and Core Build Up. Covered once per tooth.

Prefabricated Post and Core (in addition to crown). Covered once per tooth.

Prefabricated Crowns.

- Porcelain/ceramic on primary tooth covered once per 12 months.
- Stainless steel crown on primary tooth covered once per 12 months.
- Stainless steel crown on permanent tooth covered once per 36 months.
- Resin on primary tooth covered once per 12 months.
- Resin on permanent tooth covered once per 36 months.

Pin Retention. Per tooth, in addition to restoration. Covered once per tooth.

Occlusal Guards. Covered once per 12 months for members ages 13 and up with temporomandibular joint disorders.

Prosthodontic Services

Complete and Partial Dentures (removable prosthodontic services). Covered 1 time per 60 months for the replacement of extracted permanent teeth. If you have an existing denture or partial, a replacement is only covered if at least 60 months has passed and it cannot be repaired or adjusted.

Immediate Dentures. Covered once per lifetime. Does not include resin base or cast metal framework with resin base.

Overdenture (complete). Covered once per arch per 60 months.

Relines. Chairside or laboratory relines are covered once per 12 months following placement of a denture without extractions. Covered once per 6 months following placement of a denture with extractions.

Repairs and Replacement of Broken Clasps. Covered 2 per 12 months per arch, up to 3 clasps per visit. Covered only once 6 months has passed from initial placement.

Replace Missing or Broken Teeth. Covered 2 per 12 months, up to 4 teeth per visit. Covered only once 6 months has passed from initial placement.

Denture Adjustments and Repairs. Covered 2 per 12 months. Covered only once 6 months has passed from initial placement.

Tissue Conditioning. Covered 2 per 36 months.

Bridges (fixed prosthodontic services). Covered 1 time per 60 months for the replacement of extracted permanent teeth. If you have an existing bridge, a replacement is only covered if at least 60 months has passed and it cannot be repaired or adjusted.

Bridge Adjustments and Repairs. Covered 2 per 12 months. Covered only once 6 months has passed from initial placement.

Recementation of Bridge. Covered 12 months after initial placement of bridge. Covered only when given by the same provider that placed the appliance.

Single Tooth Implant Body, Abutment and Crown. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown. Some adjunctive implant services may not be covered. Implant services are covered only when exceptional medical conditions are documented, such as severe atrophy of the mandible and/or maxilla. It is recommended that you get a pretreatment estimate, so you fully understand the treatment and cost before having implant services done.

Alveoloplasty. Covered after 6 months of any extraction.

Vestibuloplasty. Covered once per arch per 60 months. Vestibuloplasty that includes grafts and/or muscle reattachment is covered once per arch per lifetime.

Facial Prosthetics. Facial prosthetics are covered under this plan, including, but not limited to;

- facial moulage
- nasal prosthesis
- orbital, ocular, and nasal prosthesis
- obturator prosthesis (modification) – covered 2 per 12 months
- feeding aids
- speech aids (modifications) – covered 2 per 12 months

- palatal lift prosthesis (modification) – covered 2 per 12 months
- surgical splint

It is recommended that you get a pretreatment estimate for facial prosthetics so you fully understand the treatment and cost before having these services done.

Medically Necessary Orthodontic Care

Orthodontic care is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. Orthodontic care can be beneficial to generally prevent disease and promote oral health. Talk to your dentist about getting a pretreatment estimate for your orthodontic treatment plan, so you have an idea upfront what the treatment and costs will be. Your or your dentist should send it to us so we can help you understand how much is covered by your benefits.

Medically Necessary Orthodontic Care. This plan will only cover orthodontic care when it is necessary to restore the form and function of the oral cavity, such as through the result of an injury or from dysfunction resulting from congenital deformities. To be considered medically necessary orthodontic care, at least one of the following criteria must be present:

- Spacing between adjacent teeth that interferes with your biting function.
- Overbite that causes the lower front (anterior) teeth to impinge on the roof of your mouth when you bite.
- The position of your jaw or teeth impairs your ability to bite or chew.
- On an objective, professional orthodontic severity index (such as the HLD Index) or consistent with current California Denti-Cal orthodontic criteria, your condition scores consistent with needing orthodontic care.

Orthodontic treatment may include the following:

- Pre-orthodontic Treatment Visits. Covered once every 3 months.
- Periodic Treatment Visits. Covered 4 times per year.
- Comprehensive or Complete Treatment. A full treatment case that includes all radiographs (such as 2D cephalometric and oral/facial images), diagnostic casts and models, orthodontic appliances and visits.
- Orthodontic Retention. Covered once per arch per course of treatment. Repair or replacement of lost or broken retainer is covered once per appliance. Replacement covered only within 24 months of placement of orthodontic retainer.
- Complex Surgical Procedures. Surgical procedures given for orthodontic reasons, such as exposing impacted or unerupted teeth, or repositioning of teeth.

How We Pay for Orthodontic Care. Because orthodontic treatment usually occurs over a long period of time, payments are made over the course of your treatment. In order for us to continue to pay for your orthodontic care, you must have continuous coverage under this plan.

The first payment for orthodontic care is made when treatment begins. Treatment begins when the appliances are installed. Your dental provider should submit the necessary forms telling us when your appliance is installed. Payments are then made at six month intervals until the treatment is finished or coverage under this plan ends.

If your orthodontic treatment is already in progress (the appliance has been installed) when you begin coverage under this plan, the orthodontic treatment benefit under this coverage will be on a pro-rated basis. We will only cover the portion of orthodontic treatment that you are given while covered under this plan. We will not pay for any portion of your treatment that was given before your effective date under this plan.

What Orthodontic Care Does NOT Include:

Coverage is NOT provided for:

- Monthly treatment visits that are billed separately – these costs will already be included in the total cost of your treatment.

- Orthodontic retention or retainers that are billed separately – these costs will already be included in the total cost of your treatment.
- Retreatment and services given due to a relapse.
- Inpatient or outpatient hospital expenses.
- Any provisional splinting, temporary procedures or interim stabilization of the teeth.

Adult Dental Benefits

We cover the following dental care services for *member*s age 19 and older when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, we will cover the least expensive.

Diagnostic and Preventive Services

Oral Exams. You may have up to 2 oral exams per calendar year. If you have more than one comprehensive exam given by the same dental office within the calendar year, the second exam will be covered as a periodic oral exam.

Radiographs (X-rays)

- Bitewings - covered at 1 series of bitewings per 24 month period.
- Full Mouth (also called complete series) or Panoramic - covered 1 time per 60 month period.
- Periapicals – up to 4 single x-rays are covered per 12 month period.
- Occlusals - up to 2 series per 24 month period.

Dental Cleaning (prophylaxis). Procedure to remove plaque, tartar (calculus), and stain from teeth. Any combination of this procedure and periodontal maintenance (See Basic Restorative Services) is covered 2 times per calendar year.

Basic Restorative Services

Periodontal Maintenance. Any combination of periodontal maintenance and dental cleanings (see Diagnostic and Preventive Services) is covered 2 times per calendar year. Covered only for members that have completed a previous periodontal treatment (surgical or non-surgical). This procedure includes the following:

- removal of bacteria from the gum pocket areas
- scaling and polishing of the teeth
- periodontal evaluation
- gum pocket measurements

Emergency Treatment (also called palliative treatment). Covered for the temporary relief of pain or infection.

Fillings (restorations). Covered once per tooth surface per 24 month period. Fillings are covered when placed on primary or permanent teeth. There are two kind of fillings covered under this plan:

- Amalgam. These are silver fillings that are used to restore decayed or fractured posterior (back) teeth.
- Composite Resin. These are tooth-colored fillings that are used to restore decayed or fractured anterior (front) teeth. If you choose to have a composite resin filling place on a back tooth, we will pay up to the *maximum allowed amount* for an amalgam filling. You will be responsible to pay for the difference in cost between the *maximum allowed amount* and the *dentist's* actual charge, plus any applicable *deductible* or *coinsurance*.

Basic Extractions. Extraction of erupted tooth or exposed root.

Brush Biopsy. For members age 20 to 39, covered 1 time per 36 month period. For members age 40 and older, covered 1 time per 12 month period.

Endodontic Services

Endodontic Therapy on Permanent Teeth. The following services are covered 1 time per tooth per lifetime.

- root canal therapy
- root canal retreatment

Periodontal Services

Basic Non-Surgical Periodontal Care. These services are to treat of diseases of the gums (gingiva) and bone that supports the teeth.

- Periodontal scaling and root planing – covered 1 time per 36 months; covered only if the tooth has a pocket depth of 4 millimeters or greater.
- Full mouth debridement – covered 1 time per lifetime.

Complex Surgical Periodontal Care. These services are surgical treatment for diseases of the gums (gingiva) and bone that supports the teeth. Only one of the below services is covered per 36 months for a single tooth (or multiple teeth in the same quadrant) and if the pocket depth of the tooth is 5 millimeters or greater.

- gingivectomy/gingivoplasty
- gingival flap
- apically positioned flap
- osseous surgery
- bone replacement graft
- pedicle soft tissue graft
- free soft tissue graft
- subepithelial connective tissue graft
- soft tissue allograft
- combined connective tissue and double pedicle graft
- distal/proximal wedge – covered on natural teeth only

Oral Surgery Services

Complex Surgical Extractions. Surgical removal of 3rd molars are covered only when symptoms of oral pathology exists.

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

Other Complex Surgical Procedures. The following services are covered once in a 60 months period. Covered only when needed to prepare for dentures.

- alveoloplasty
- vestibuloplasty
- removal of exostosis-per site
- surgical reduction of osseous tuberosity

Surgical Reduction of Fibrous Tuberosity. Covered 1 time per 6 months.

Intravenous Conscious Sedation, IV Sedation and General Anesthesia. Covered only when given with a covered complex surgical service. The service must be given in a dentist's office by the *dentist* or an employee of the *dentist* that is certified in their profession to give anesthesia services

Major Restorative Services

Gold Foil Restorations. Covered 1 time per 24-month period. Gold foil restorations are covered at the same frequency as an amalgam filling (see Basic Restorative Services). Gold foil restorations will be paid up to the same maximum allowed amount for an amalgam filling. You are responsible to pay for any amount over the maximum allowed amount, plus any applicable deductible and coinsurance.

Inlays. Inlays are covered at the same frequency as an amalgam filling (see Basic Restorative Services). Inlays will be paid up to the same maximum allowed amount as for an amalgam filling. If you chose to have a tooth colored inlay (such as composite resin, porcelain) you are responsible to pay for any amount over the maximum allowed amount, plus any applicable deductible and coinsurance.

Onlays and/or Permanent Crowns. Covered 1 time per 7 year period. Only covered on a permanent tooth. To be covered, the tooth must have extensive loss of natural structure due to decay or fracture so that another restoration (such as a filling or inlay) cannot be used to restore the tooth. We will pay up to the maximum allowed amount for a porcelain to noble metal crown. If you choose to have another type of crown, you are responsible to pay for the difference plus any applicable deductible and coinsurance.

Implant Crowns. See the implant procedures description in Prosthodontic Services.

Recement Inlay, Onlay or Crown. Covered 6 months after initial placement.

Crown Repair. Covered 1 time per 12 month period per tooth. The narrative from your treating *dentist* must support the procedure.

Restorative Cast Post and Core Build-Up. Includes 1 post per tooth and 1 pin per surface.- Covered 1 time per 7 year period. Covered only if needed to retain an indirectly fabricated restoration (such as a crown) due to extensive loss of tooth structure due to decay or fracture.

Prosthodontic Services

We will not cover the initial installation of an implant(s), full or partial dentures, or fixed bridgework to replace a tooth (teeth) that was extracted prior to becoming a *member* under this *plan* until you have been continually covered under this *plan* for more than 12 months.

Tissue Conditioning. Covered 1 time per 24 month period.

Reline and Rebase. Covered 1 per 24 month period as long as the appliance (denture, partial or bridge) is the permanent appliance. Covered once 6 months has passed from the initial placement of the appliance

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasps. Covered 1 per 6-month period as long as the appliance (denture, partial or bridge) is the permanent appliance. Covered once 6 months has passed from the initial placement of the appliance and the narrative from your treating dentist supports the service.

Denture Adjustments. Covered 2 times per 12 month period as long as the denture is the permanent appliance. Covered once 6 months has passed from the initial placement of the denture.

Partial and Bridge Adjustments - Covered 2 times per 24 month period as long as the partial or bridge is the permanent appliance. Covered once 6 months has passed from the initial placement of the partial or bridge.

Dentures and Partials (removable prosthetic services). Covered 1 time per 7 year period for the replacement of extracted permanent teeth. If you have an existing denture or partial, a replacement is only covered if at least 7 years has passed and it cannot be repaired or adjusted.

Bridges (**fixed prosthetic services).** Covered 1 time per 7 year period for the replacement of extracted permanent teeth. If you have an existing bridge, a replacement is only covered if at least 7 years has passed and it cannot be repaired or adjusted. In order for the bridge to be covered, the following must apply:

- a natural healthy and sound tooth is present to service as the anterior and posterior retainer;
- there are no other missing teeth in the same arch that have been replaced with a removable partial denture; and
- none of the individual units (teeth) of the bridge has had a crown or cast restoration covered under this plan in the last 7 years.

We will cover the least costly, commonly performed course of treatment. If there are multiple missing teeth, we may cover a partial denture instead of the bridge. If you still choose to get the bridge, you will be responsible to pay the difference in cost, plus any applicable deductible and coinsurance.

Recementation of Bridge (fixed prosthetic). Covered 1 time per 12 months.

Implant Supported Fixed and Removable Prosthetic. Implants and related services are NOT covered under this plan. . This coverage is just for the restoration (such as a crown, bridge, partial or denture) that is retained, supported and stabilized by an implant. We will pay for the least expensive, professionally acceptable treatment. For example, a single crown to restore an open space will be paid at the *maximum allowed amount* for one unit of a fixed partial denture pontic. If you choose a service that is more than our payment, you are responsible for the difference, plus any applicable *deductible* and *coinsurance*.

Exclusions

The following exclusions apply to all *member*s:

- Dental services which a *member* would be entitled to receive for a nominal charge or without charge if this coverage were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a *member* receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this *plan* will not be reduced or denied because dental services are rendered to a subscriber or *dependent* who is eligible for or receiving medical assistance.
- Procedures which are not generally accepted standards of dental practice within the organized dental community in California.
- Dental services or health care services not specifically listed in the Covered Services section of this EOC (including any hospital charges or prescription drug charges).
- Dental services completed prior to the date the *member* became eligible for coverage.
- Analgesia, analgesia agents, medicines and drugs for surgical or non-surgical care.
- Local anesthetic when billed separately from a *covered service*, as this is a part of the final service, such as for restoration services (fillings, crowns).
- Dental services performed other than by a licensed dentist, licensed physician, his or her employees.
- Dental care services you received which you are not legally obligated to pay or dental care services you received that would be no charge to you in the absence of insurance.
- *Covered services* received from a person who lives in the *member's* home or who is related to the *member* by blood, marriage or adoption.
- 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.
- Dental services provided by *dentists* solely for the purpose of improving the appearance of the tooth when the tooth structure and function are satisfactory and no pathologic conditions (cavities) exist. This include tooth whitening agents, bonding, and veneers or restorations (such as fillings) placed for preventive purposes.
- Incomplete services where the final permanent appliance (denture, partial, bridge) or restoration (filling, crown) has not been placed.
- Athletic mouth guards, enamel microabrasion and odontoplasty.
- Bacteriologic tests.
- Cytology sample collection.
- Separate services billed when they are an inherent component of another *covered service*.
- Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case.
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bars, and precision attachments.
- Provisional splinting, temporary procedures or interim stabilization.
- Cone beam images.
- Anatomical crown exposure.

- Temporary anchorage devices.
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Services or supplies that are not *medically necessary*.
- Stress breakers.
- Hemisection.
- Retrograde filling.
- 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.

The following exclusions apply to *member*s age 19 and older:

- Services of anesthesiologists.
- Analgesia, analgesic agents, medicines, or drugs for non-surgical or surgical dental care.
- Any material implanted or grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration, dental implant procedures and associated fixtures, or surgical removal of implants.
- Orthodontic treatment services, including surgical exposure of impacted or unerupted teeth solely for orthodontic purposes.
- Corrections of congenital conditions during the first 24 months of continuous coverage under this *plan*.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited.
- Incomplete root canals.
- Dental implant maintenance or repair to an implant or implant abutment.
- Intentional reimplantation.
- Surgical repositioning of teeth.
- Temporary, provisional or interim crown.

How to File Claims

Participating dentists will submit claims for *covered services* 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. This section will tell you how to file a claim.

Claim Forms. When you send us notice of claim, we will send you a claim form within 15 days. If such form is not furnished within 15 days after your notice of claim, you will have complied with the requirements of this *plan* for proof of claim if you submit other proof of claim, such as written proof of the occurrence, character, and the extent giving rise to the claim. Such proof should include:

- Name of patient
- Patient's relationship to you
- Identification number
- Date, type and place of service
- Your signature and the dentist's signature

We also accept the standard American Dental Association (ADA) claim form used by most *dentist*s.

Proof of Claim. We must receive your written proofs of claim within 180 days after the date you received dental care. If proof of claim is not sent within that time, your claim will not be reduced or denied, as long as it was not possible to send your proof. However, you must send it as soon as reasonably possible. In any case, the proof of claim must be sent to us no later than 15 months after the date of service, unless you were legally incapacitated.

Please send your claim forms or other proof of claim should be submitted to:

Anthem Blue Cross
[PO Box 1115
Minneapolis, MN 55440-1115]
[(877) 567-1804]

Time of Payment of Claim. Any payments for *covered service*s will be made immediately upon receipt of proper written proof of claim, but no later than 30 days.

Payment of Claims. Should loss of life occur, we will pay benefits to your designated beneficiary. If you have no designated beneficiary, we will pay benefits to your estate.

General Provisions

Independent Contractors: Our relationship with *dentists* is that of an independent contractor. *Dentists* are not our agents or employees, nor are we, or any of our employees, an employee or agent of any *dentist*. We are not responsible for any damages or injuries as a result of receiving services from *dentists*.

Worker's Compensation Insurance. This *plan* does not affect any requirement for coverage by worker's compensation insurance. It also does not replace that insurance.

Public Policy Participation: We have established a public policy committee that we call our Consumer Relations Committee. This committee includes providers, members of the plan, and a member of our Board of Directors. If you would like to be considered for this committee, please write to us at [Anthem Blue Cross, PO Box 1115, Minneapolis, MN 55440-1115]. The Committee advises our Board of Directors (the Board) about how to assure the comfort, convenience, and dignity of our members. The Committee may also review our financial information, as well as information about the complaints we receive.

Benefits Not Transferable. You and your *dependents* are the only persons able to receive benefits under this *plan*. You are not able to transfer your benefits to anyone else.

Continuation of Care. 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 plan 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 plan, until the treatment in progress is completed, unless reasonable and medically appropriate provision is made for the completion of treatment in progress by another *participating dentist*.

Transition Assistance. In certain situations, new *member*s to this *plan* may be able to complete their dental care with a *non-participating dentist*. We will ask the *dentist* to accept the terms and conditions of the current contract we have with our *participating dentists*. If the *dentist* does not agree to our terms and conditions, we are not required to cover the completion of your care with them. If you would like to request continuity of care or to obtain a copy of the written policy for continuity of care, please contact us.

Circumstances Beyond Our Control. In the event of circumstances beyond our control, including but not limited to a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within our control, disability of a significant part of a participating dentist's personnel or similar causes, or the rendering of dental care services provided under this EOC is delayed or rendered impractical, we will make a good faith effort to arrange for an alternative method of providing coverage. In such event, we and participating dentists will render dental care services provided under this plan insofar as practical, and according to their best judgment; but the plan and participating dentists will 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.

Modifications. We have the right upon renewal, or at any time during the duration of your *plan* to modify or otherwise change the terms and conditions of your *plan* 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 *plan*, including without limitation, premiums, *covered service*s, and *deductible*s.

Right of Recovery. When the amount we paid exceeds our liability under this EOC, 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.

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

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.

Grievance Procedures

Grievances

If you are dissatisfied about any aspect of the Anthem Blue Cross Dental services or claim processing or the services or treatment received by a dentist participating in our network, you may file a grievance verbally by contacting the Customer Service Department toll free telephone number identified on your member ID card or in writing to Anthem Blue Cross Dental Grievances and Appeals, [P.O. Box 1122, Minneapolis, MN 55440-1122]. Also, you may access the company web site at [www.anthem.com/ca] which provides a method for a member to file a grievance online. All grievances relating to dental care and coverage are referred to the Anthem Dental Grievances and Appeals Department for investigation and response. You may file a grievance for at least 180 days following any incident or action that is the subject of your dissatisfaction. If you need assistance filing a grievance please let your provider or customer service representative know.

Grievance resolution may involve review of your records and x-rays, which, if needed will be requested by the Grievance and Appeals analyst, Dental Director, or dental consultant, utilizing mail, fax or secure email. Grievances will be resolved within thirty (30) calendar days from Anthem's receipt of your expression of dissatisfaction.

If you are dissatisfied with the resolution of your grievance, or if your grievance has not been resolved for more than 30 calendar days, you may submit your grievance to the California Department of Managed Health Care for review (see the DEPARTMENT OF MANAGED HEALTH CARE section below). If your case involves an imminent threat to your health, you are not required to complete our grievance process, but may immediately submit your grievance to the Department of Managed Health Care for review.

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at the **telephone number listed on your identification card** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are *experimental or investigational* in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Web site (**http://www.hmohelp.ca.gov**) has complaint forms, IMR applications forms and instructions online.

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 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 disputes relating to the delivery of services under the plan/policy, 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 permitted and provided by federal and 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 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. 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 member and Anthem Blue Cross, or by order of the court, if the member and Anthem Blue Cross 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 or Anthem Blue Cross agrees 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
PO Box 1115
Minneapolis, MN 55440-1115]

Definitions

The meanings of key terms used in this *plan* are shown below. When any of the terms below are italicized in your booklet, you should refer to this section.

Coinsurance. A percentage of the *maximum allowed amount* for which you are responsible to pay.

Coverage Percentage. The percentage of the *maximum allowed amount* that we will pay for *covered services*. Coverage percentages are listed in the Summary of Dental Benefits.

Coverage Year. A 12-month period in which *deductibles* and *coverage year maximums* apply. Your *coverage year* is January 1st through December 31st.

Coverage Year Maximum. The maximum amount we will pay for *covered service*s for each *member* during the *coverage year*. See the Summary of Dental Benefits for your coverage year maximums.

Covered Services. Services or treatments that are performed, prescribed, directed or authorized by a *dentist*. Covered services are listed in the section What is Covered. To be considered covered services, services must be:

- within the scope of the license of the *dentist* performing the service;
- given while you are covered under this *plan*;
- a service that is not excluded or limited under this *plan*; and
- specifically listed as a benefit within this booklet.

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

Dependent. A member of the *subscriber's* family who is eligible to enroll in this *plan.* See the section Who is Covered an When for more information on which dependents are eligible.

Effective Date. The date your coverage begins under this *plan*. Your effective date will be listed on your ID card.

Evidence of Coverage (EOC). This booklet, which are the terms and conditions of your dental benefits.

Experimental or Investigative. Services that are not recognized and accepted by the American Dental Association (ADA) as standard dental practice.

Maximum Allowed Amount. The maximum amount we will pay for *covered service*s. See the section Dentists and Claims Payments for more information on how we determine the maximum allowed amounts.

Medically Necessary. Procedures, supplies, equipment or services that we find to be:

- Appropriate for the symptoms, diagnosis or treatment of a dental condition;
- Provided for the diagnosis or direct care and treatment of the dental condition;
- Within the standards of good dental practice within the organized dental community;
- Not primarily for the convenience of the patient's dentist or other provider;
- The most appropriate procedure, supply, equipment or service that:
    - Has valid scientific evidence showing that the expected health benefits are clinically significant and produce a greater likelihood of benefit, without disproportionately greater risk of harm or complications for the patient, than other possible alternatives; and
    - When other generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable.

Medically Necessary Orthodontic Care. See Medically Necessary Orthodontic Care under the What is Covered section for more information.

Member. Any *subscriber* or *dependent* that is covered under this *plan*.

Non-Participating Dentist. A *dentist* who has NOT signed a written agreement with us to service the program identified in this booklet.

Participating Dentist. A *dentist* who has signed a written agreement with us to service the program identified in this booklet. Participating dentists have agreed to our *maximum allowed amount* as payment in full for *covered service*s.

Pediatric Dental Essential Health Benefits (EHB). For the purposes of this coverage, those pediatric oral services that we are required to cover under the Patient Protection and Affordable Care Act and any other application regulations. EHB and its provisions apply to *member*s through the end of the month in which they turn 19.

Plan. The entire set of benefits, conditions, exclusions and limitations that make up your coverage. It consists of this booklet, your application and any endorsements or amendments that may be attached.

Qualified Health Plan (QHP). A health or dental plan that is certified to be sold on the Exchange.

Qualified Individual. An individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

Subscriber. The person that has applied for coverage and been accepted by us to be covered under this *plan*.