Dental Certificate of Coverage

SISC (SELF INSURED SCHOOLS OF CALIFORNIA)

Group Number C00121

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

Anthem Dental

Essential Choice

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

DENTAL CERTIFICATE OF COVERAGE

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

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

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

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

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

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

ADMINISTRATION

PLAN SPONSOR, FIDUCIARY AND ADMINISTRATOR:
SISC (SELF INSURED SCHOOLS OF CALIFORNIA)
2000 K Street
Bakersfield CA 93301
661-636-4410

AGENT FOR SERVICE OF LEGAL PROCESS:
SISC (SELF INSURED SCHOOLS OF CALIFORNIA)
2000 K Street
Bakersfield CA 93301
661-636-4410

FUNDING: This Plan is self-funded. Your contribution towards the cost of the coverage under the Plan will be determined by the Employer each year and communicated to you prior to the effective date of any changes in the cost of the coverage.

GROUP NUMBER: C00121

PLAN BENEFITS ADMINISTERED BY:
Anthem Insurance Companies, Inc.
P.O. Box 1115
Minneapolis, Minnesota 55440-1115
(844) 729-1565

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SUMMARY OF BENEFITS

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

Coverage Year	Calendar Year - A 12-month period starting January 1
Dependent Age Limit	To the end of the month in which the child attains age 26.
Benefit Waiting Period	There are no benefit waiting periods.

DENTAL BENEFIT MAXIMUMS

Dental Benefit Maximums

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

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

Coverage Year Maximum for Participating Dentist	$4,000.00 per Member
Coverage Year Maximum for Non-Participating Dentist	$250.00 per Member
Orthodontic Services Lifetime Maximum	$2,000.00 per Member

Your benefits for the services of a Participating Dentist, excluding Orthodontic Services. . We will not pay any benefit in excess of that amount during a Coverage Year.

Your benefits for the services of a Non-Participating Dentist, excluding Orthodontic Services. [. We will not pay any benefit in excess of that amount during a Coverage Year.

If you transfer or move from one SISC member district to another, you do not receive a new maximum because you transferred or moved to another SISC district. The maximum amount paid by the Anthem under both plans will not exceed the maximum under your current plan.

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

disease at the time of the accident. The initial claim for the Accident and all claims related to the Accident must be submitted within 12 months following the date of the Accident.

DEDUCTIBLES

Deductible (combined for Participating and Non-Participating Dentist)

There Is no deductible applied to this plan.

Dental Covered Services

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

Annual Benefit Maximums*	Participating Dentist $4,000	Non-Participating Dentist $250
Diagnostic and Preventive Services	100%	100%
Basic Restorative Services	100%	100%
Endodontic Services	100%	100%
Periodontal Services	100%	100%
Oral Surgery Services	100%	100%
Major Restorative Services	100%	100%
Prosthodontic Services	50%	50%
Orthodontic Services	100%	100%

***Refer to the Dental benefit Maximums explained on page 5.**

DEFINITIONS

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

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

Accidental Dental Injury Maximum - The maximum dollar amount payable per Accident for Covered Services provided to a Member due to an Accident. Refer to the **Summary of Benefits** for the Accidental Dental Injury Maximum amount.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ELIGIBILITY AND ENROLLMENT

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Subscriber's**
   a. A classified non-temporary *subscriber* who works the minimum number of hours required by SISC III and the *participating employer*.
   b. A certificated *subscriber* under contract and who works a minimum of 50% of a certificated job.

   c. A *retired employee* who retired from active employment and was covered under a *plan* sponsored by SISC III immediately prior to retirement.

2. **Dependent's**
   The following persons are eligible to enroll as *dependents*: (a) Either the *subscribers spouse* or *domestic partner*; and (b) A child.

Definition of Dependent

1. **Spouse** is the *subscriber's* spouse as recognized under state or federal law. This includes same sex spouses when legally married in a state that recognizes same sex marriages. Spouse does not include any person who is in active service in the armed forces.

Note: Legally separated spouses are eligible for coverage under this *plan*.

2. **Domestic partner** is the *subscriber's* domestic partner. Domestic partner does not include any person who is in active service in the armed forces. In order for the *subscriber* to include their domestic partner as a *dependent*, the *subscriber* and domestic partner must meet the following requirements:

   a. Both persons have a common residence.

   b. Both persons agree to be jointly responsible for each other's basic living expenses incurred during their domestic partnership.

   c. Neither person is married or a member of another domestic partnership.

   d. The two persons are not related by blood in a way that would prevent them from being married to each other in California.

   e. Both persons are at least 18 years of age.

   f. Either of the following:

      i. Both persons are members of the same sex; or
      ii. One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged members. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both of the persons are over the age of 62.

   g. Both persons are capable of consenting to the domestic partnership.

h. Neither person has previously filed: (1) a Declaration of Domestic Partnership with the California Secretary of State, or a similar form with another governing jurisdiction, that has not been terminated pursuant to the laws of California, or of that other jurisdiction; or, if (1) does not apply, (2) an affidavit with SISC III declaring they are part of a domestic partnership that they have not been terminated by giving SISC III written notice that it has.

i. It has been at least six months since: (1) the date that the Notice of Termination of Domestic Partnership was filed with the California Secretary of State, or similar form was filed with another governing authority; or, if (1) does not apply, (2) either person has given written notice to SISC III that the domestic partnership they declared in an affidavit, given to SISC III, has terminated. This item does not apply if the previous domestic partnership ended because one of the partners died or married.

j. Both partners:

i. If they reside in the State of California, must file a Declaration of Domestic Partnership with the California Secretary of State pursuant to Division 2.5 of the California Family Code to establish their domestic partnership. The *subscriber* must provide SISC III with a certified copy of the Declaration of Domestic Partnership that was filed with the California Secretary of State;

ii. If they reside in another state or governing jurisdiction that registers domestic partnerships, they must register their domestic partnership with that state or governing jurisdiction. The *subscriber* must provide SISC III with a certified copy of the document that was filed with the governing jurisdiction registering their domestic partnership; or

iii. If the *subscriber* and their domestic partner do not reside in a city, county or state that allows them to register as domestic partners, they must provide SISC III with a signed, notarized, affidavit certifying they meet all of the requirements set forth in 2.a through 2.i above, inclusive.

Note: For the purposes of 2.j.i above, if the *subscriber* and their domestic partner registered their relationship prior to July 1, 2000, with a local governing jurisdiction in California, in lieu of supplying SISC III with a certified copy of the Declaration of Domestic Partnership (a State of California form), the *subscriber* may provide SISC III with a certified copy of the form filed with the local governing jurisdiction.

For the purposes of this provision, the following definitions apply:

"Have a common residence" means that both domestic partners share the same residence. It is not necessary that the legal right to possess the common residence be in both of their names. Two people have a common residence even if one or both have additional residences. Domestic partners do not cease to have a common residence if one leaves the common residence but intends to return.

"Basic living expenses" means shelter, utilities, and all other costs directly related to the maintenance of the common household of the common residence of the domestic partners. It also means any other cost, such as medical care, if some or all of the cost is paid as a benefit because a person is another person's domestic partner.

“Joint responsibility" means that each partner agrees to provide for the other partner's basic living expenses if the partner is unable to provide for herself or himself. Persons to whom these expenses are owed may enforce this responsibility if, in extending credit or providing goods or services, they relied on the existence of the domestic partnership and the agreement of both partners to be jointly responsible for those specific expenses.

3. **Child** is the *subscriber's*, *spouse's* or *domestic partner's,* natural child, stepchild, legally adopted child, or a child for whom the *subscriber*, *spouse* or *domestic partner* has been appointed legal guardian by a court of law or has legal custody according to a court of law, subject to the following:

a. The child is under 26 years of age.

b. The unmarried child is 26 years of age, or older and: (i) was covered under the *prior plan*, was covered as a *dependent* of the *subscriber* under another plan or health insurer, or has six or more months of other *creditable coverage*; (ii) continues to be dependent on the *subscriber, spouse or domestic partner* for financial support and maintenance as defined by IRS rules; or (iii) is incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the child is incapable of self-sustaining employment due to a physical or mental condition. SISC III must receive the certification, at no expense to itself, within 60-days of the date the *subscriber* receives the request from SISC III. SISC III may request proof of continuing dependency and that a physical or mental condition still exists, but not more often than once each year after the initial certification. This exception will last until the child is no longer chiefly dependent *on the subscriber, spouse or domestic partner* for financial support as defined by IRS rules and maintenance due to a continuing physical or mental condition. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

c. A child who is in the process of being adopted is considered a legally adopted child if SISC III receives legal evidence of both: (i) the intent to adopt; and (ii) that the *subscriber*, *spouse* or *domestic partner* have either: (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption.

Legal evidence to control the health care of the child means a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or relinquishment form, signed by the child's birth parent, or other appropriate authority, or in the absence of a written document, other evidence of the *subscriber's*, the *spouse's* or *domestic partner's* right to control the health care of the child.

d. A Child for whom the *subscriber*, *spouse* or *domestic partner* is a legal guardian is considered eligible on the date of the court decree. SISC III must receive legal evidence of the decree. Such Child must be enrolled as set forth in the ENROLLMENT and EFFECTIVE DATE provisions below.

You can enroll both as an employee and a spouse or domestic partner. If you and your spouse, or domestic partner, are both covered as employees under this *plan*, your children may be covered as family members of both. However, the total amount of benefits we will pay will not be more than the amount covered.

Important Note: Before a *dependent's* enrollment is processed, SISC III reserves the right to request documentation or proof of his or her eligibility (that is a marriage certificate, a birth certificate, a court decree, adoption papers or any other documentation that SISC deems relevant and appropriate). SISC also reserves the right to request any relevant and appropriate documentation at any time to confirm a *dependent's* continued eligibility. In addition, before you can enroll your domestic partner, SISC III reserves the right to request documentation or proof to support the domestic partnership (that is a Declaration of Domestic Partnership or properly executed affidavit as noted above under **Domestic Partner**).

ELIGIBILITY DATE

1. For *subscribers,* you become eligible for coverage in accordance with rules established by your employer, but the effective date must be the first of the month. For specific information about your employer's eligibility rules for coverage, please contact your Human Resources or Benefits Department.

2. For *dependents,* you become eligible for coverage on the later of: (a) the date the *subscriber* becomes eligible for coverage; or, (b) the date you meet the *dependent* definition.

ENROLLMENT

To enroll as a *subscriber,* or to enroll *dependents,* the *subscriber* must properly file an application with SISC III. An application is considered properly filed, only if it is personally signed, dated, and given to SISC III within 31 days from your eligibility date. If any of these steps are not followed, your coverage may be denied or you may have to wait until the next Open Enrollment Period to enroll.

EFFECTIVE DATE
Your effective date of coverage is subject to the timely payment of subscription charges on your behalf. The date you become covered is determined as follows:

1. **Timely Enrollment:** If you enroll for coverage before, on, or within 31 days after your eligibility date, then your coverage will begin as follows: (a) for subscribers, on your eligibility date; and (b) for family members, on the later of (i) the date the subscriber's coverage begins, or (ii) the first day of the month after the family member becomes eligible. If you become eligible before the agreement takes effect, coverage begins on the effective date of the agreement, provided the enrollment application is on time and in order.
2. **Late Enrollment.** If you fail to enroll within 31 days after your eligibility date, you must wait until the group's next Open Enrollment Period to enroll.
3. **Disenrollment:** If you voluntarily choose to disenroll a *dependent* from coverage under this *plan* during the open enrollment period, you will be eligible to reapply for coverage as set forth in the "Enrollment" provision above, during the next Open Enrollment Period (see OPEN ENROLLMENT PERIOD)

Note: Disenrollment is not allowed for qualified subscribers. Disenrollment of dependents outside of the open enrollment period is only allowed due to a qualifying event.

For late enrollees and dis-enrollees: You may enroll earlier than the group's next Open Enrollment Period if you meet any of the conditions listed under Special Enrollment Periods.

Important Note for Newborn and Newly-Adopted Children. If the Subscriber (or spouse or domestic partner, if the spouse or domestic partner is enrolled) is already covered: (1) any child born to the subscriber, spouse or domestic partner will be enrolled from the moment of birth; and (2) any child being adopted by the Subscriber, spouse or domestic partner will be enrolled from the date on which either: (a) the adoptive child's birth parent, or other appropriate legal authority, signs a written document granting the Subscriber, spouse or domestic partner the right to control the health care of the child (in the absence of a written document, other evidence of the Subscriber's, spouse's or domestic partner's right to control the health care of the child may be used); or (b) the Subscriber, spouse or domestic partner assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption. The

written document referred to above includes, but is not limited to, a health facility minor release report, a medical authorization form, or relinquishment form.

In both cases, coverage will be in effect for 31 days. For coverage to continue beyond this 31-day period, the *subscriber* must enroll the *child* within the 31-day period by submitting a membership change form to SISC III. Any membership change form not filed within the 31-day period must be submitted to SISC III during the Open Enrollment Period generally held during September of each year for an effective date of October1.

Special Enrollment Periods
You may enroll without waiting for the group's next open enrollment period if you are otherwise eligible under any one of the circumstances set forth below:

1. For less than full-time *subscribers* or *subscribers* who receive less than the amount contributed toward the cost of a full-time *subscriber:*

    a. If you declined coverage you must file an application with SISC III to enroll within a time period ending 31 days after: (a) the date of an increase in the number of hours worked; or (b) the date of an increase in amount contributed by the *participating employer.* Coverage will become effective on the first day of the month following the date of the event.

    b. If you declined coverage because you were covered elsewhere, you must file an application with SISC III to enroll within a time period ending 31 days after the date you lose coverage. You must have signed a declination of coverage form when first eligible or during the Open Enrollment Period stating you declined coverage because you were covered elsewhere and evidence of loss of coverage must be submitted to SISC III with your application for enrollment. Coverage will become effective on the first day of the month following the date you lost coverage.

2. For all other *subscribers* and eligible *dependents:*

You have met all of the following requirements:

a. You were covered as a member or dependent under either:
    i. Another employer group health plan or health insurance coverage, including coverage under a COBRA or CalCOBRA continuation; or

    ii. A state Medicaid plan or under a state child health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program.

    iii. You certified in writing at the time you became eligible for coverage under this *plan* that you were declining coverage under this *plan* or disenrolling because you were covered under another health plan as stated above and you were given written notice that if you choose to enroll later, you may be required to wait until the next open enrollment period to do so.

    iv. Your coverage under the other health plan wherein you were covered as a member or dependent ended as follows:

        a. If the other health plan was another employer group health plan or health insurance coverage, including coverage under a COBRA or CalCOBRA continuation, coverage ended because you lost eligibility under the other plan, your coverage under a COBRA or CalCOBRA continuation was exhausted, or employer contributions toward coverage under the other plan terminated.

        Loss of eligibility for coverage under an employer group health plan or health insurance includes loss of eligibility due to termination of employment or change in employment

status, reduction in the number of hours worked, loss of dependent status under the terms of the *plan*, termination of the other plan, legal separation, divorce, death of the person through whom you were covered, and any loss of eligibility for coverage after a period of time that is measured by reference to any of the foregoing.

b. If the other health plan was a state Medicaid plan or a state child health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program, coverage ended because you lost eligibility under the program. You must properly file an application with SISC III within 60 days after the date your coverage ended.

v. You properly file an application with SISC III within 31 days from the date on which you lose coverage.

b. A court has ordered coverage be provided under your employee health plan for: (i) a *spouse*; (ii) a *domestic partner*; or (iii) a dependent *child*, but only if the *spouse*, *domestic partner* and/or dependent *child* meets the eligibility requirements of the *plan.* Application must be filed within 31 days from the date the court order is issued.

c. You have a change in family status through either marriage or domestic partnership, or the birth, adoption, or placement for adoption of a *child*:

i. If you are enrolling following marriage or domestic partnership, you and your new *spouse* or *domestic partner*, must enroll within 31 days of the date of marriage or domestic partnership. Your new *spouse* or *domestic partner's* children may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Coverage will be effective on the first day of the month following the date you file the enrollment application.

ii. If you are enrolling following the birth, adoption, or placement for adoption of a *child*, your *spouse* (if you are already married) or *domestic partner*, who is eligible but not enrolled, may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Application must be made within 31 days of the birth or date of adoption or placement for adoption; coverage will be effective on the first day of the month following the date of birth. For adoption, or placement for adoption coverage will be effective as of the date of the court decree.

3. You are an employee who is a reservist as defined by state or federal law, who terminated coverage as a result of being ordered to military service as defined under state or federal law, and apply for reinstatement of coverage following reemployment with your employer. Your coverage will be reinstated without any waiting period. The coverage of any dependents whose coverage was also terminated will also be reinstated. For dependents, this applies only to dependents who were covered under the plan and whose coverage terminated when the employee's coverage terminated. Other dependents who were not covered may not enroll at this time unless they qualify under another of the circumstances listed above.

Effective date of coverage. For enrollments during a special enrollment period as described above, coverage will be effective on the first day of the month following the date you file the enrollment application, except as specified below:

1. If a court has ordered that coverage be provided for a dependent child, coverage will become effective for that child on the earlier of (a) the first day of the month following the date you file the enrollment application or (b) within 30 days after we receive a copy of the court order or of a request from the district attorney, either parent or the person having custody of the child, the employer, or the Group administrator.

3. For reservists and their dependents applying for reinstatement of coverage following reemployment with the employer, coverage will be effective as of the date of reemployment.

OPEN ENROLLMENT PERIOD

The group has an open enrollment period once each year, during open enrollment. During that time, an individual who meets the eligibility requirements as a subscriber under this plan may enroll. A Subscriber may also enroll any eligible family members at that time. Persons eligible to enroll as family members may enroll only under the Subscriber's plan.

For anyone so enrolling, coverage under this plan will begin on the first day of the month following the end of the Open Enrollment Period. Coverage under the former plan ends when coverage under this Plan begins.

HOW COVERAGE ENDS

Coverage may be cancelled without notice from SISC III for any of the reasons listed below. SISC III does not provide notice of cancellation to members, but will notify the *participating employer*.

1. **Subscriber**

a. If the *participation agreement* between the *participating employer* and SISC III terminates, the ***subscriber's*** coverage ends at the same time. Either the *participating employer* or SISC III may cancel or change the *participation agreement* without notice to *subscribers*.

b. If the *participating employer* no longer provides coverage for the class of members to which the *subscriber* belongs, the ***subscriber's*** coverage ends when coverage for that class ends.

c. If the *subscriber* no longer meets the eligibility requirements established by SISC III in the *participation agreement*, the ***subscriber's*** coverage ends as of the next required monthly contribution due date. This is usually the first of the month.

d. If required monthly contributions are not paid on the ***subscriber's*** behalf, the ***subscriber's*** coverage will end on the first day of the period for which required monthly contributions are not paid.

e. If less than full-time *subscribers* or *subscribers* who receive less than the amount contributed toward the cost of a full-time *subscriber* voluntarily cancel coverage, coverage ends on the first day of the month following a 30-day notice.

f. If a *retired employee* does not elect coverage upon his or her retirement, coverage ends on the first day of the month immediately following his or her retirement date. If a *retired employee* declines district coverage, the *retired employee* may not elect coverage at a future date.

Exception to item c.:

If required monthly contributions are paid, coverage may continue for a *subscriber* who is granted a temporary leave of absence up to six months, a sabbatical year's leave of absence of up to 12 months, or an extended leave of absence due to illness certified annually by the *participating employer*.

2. **Dependents**

a. If coverage for the *subscriber* ends, coverage for *dependents* ends at the same time.

b. If coverage for *dependents* ceases to be available to the *subscriber*, ***dependent's*** coverage ends on that date.

c. If the *participating employer* fails to pay the required monthly contributions on behalf of a *dependent*, coverage ends on the last date for which the *participating employer* made this payment.

d. If a ***dependent's*** coverage is canceled, coverage ends on the first day of the month following a written notice within 31 days of a qualifying event.

e. If a *dependent* no longer meets the requirements set forth in the "Eligible Status" provision of HOW COVERAGE BEGINS, coverage ends on the first day of the month following that date.

Exceptions to item e.:

Handicapped Children: If a *child* reaches the age limits shown in the "Eligible Status" provision of this section, the *child* will continue to qualify as a *dependent* if he or she is (i) covered under this *plan,* (ii) still chiefly dependent on the *subscriber*, *spouse* or *domestic partner* for support and maintenance as defined by IRS rules, and (iii) incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the *child* has a physical or mental condition that makes the child incapable of obtaining self-sustaining employment. Anthem will notify the *subscriber* that the *child's* coverage will end when the *child* reaches the *plan's* upper age limit at least 90-days prior to the date the *child* reaches that age. The *subscriber* must send SISC III proof of the *child's* physical or mental condition within 60-days of the date the *subscriber* receives Anthem's request. If SISC III does not complete their determination of the *child's* continuing eligibility by the date the *child* reaches the *plan's* upper age limit, the *child* will remain covered pending determination by SISC III. When a period of two years has passed, SISC III may request proof of continuing dependency due to a continuing physical or mental condition, but not more often than once each year. This exception will last until the *child* is no longer chiefly dependent on the *subscriber*, *spouse* or *domestic partner* for support and maintenance or a physical or mental condition no longer exists. A *child* is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

All conditions of eligibility shall be in accordance with the eligibility rules adopted by SISC III.

Note: If a marriage or domestic partnership terminates, the *subscriber* must give or send to SISC III written notice of the termination. Coverage for a former *spouse* or *domestic partner*, if any, ends according to the "Eligible Status" provisions. If SISC III suffers a loss as a result of the *subscriber* failing to notify them of the termination of their marriage or domestic partnership, SISC III may seek recovery from the *subscriber* for any actual loss resulting thereby. Failure to provide written notice to SISC III will not delay or prevent termination of the marriage or domestic partnership. If the *subscriber* notifies the *plan administrator* in writing to cancel coverage for a former *spouse* or *domestic partner* and the *children* of the *spouse* or *domestic partner*, if any, immediately upon termination of the *subscriber's* marriage or domestic partnership, such notice will be considered compliance with the requirements of this provision.

You may be entitled to continued benefits under terms which are specified elsewhere under CONTINUATION OF COVERAGE, CONTINUATION FOR DISABLED DISTRICT MEMBERS, COVERAGE FOR SURVIVING SPOUSES OF CERTIFICATED MEMBERS, CONTINUATION DURING LABOR DISPUTE, and EXTENSION OF BENEFITS.

CONTINUATION OF COVERAGE

Continuation of Coverage (COBRA)

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

QUALIFYING EVENT	WHO MAY CONTINUE	MAXIMUM CONTINUATION PERIOD
Employment ends, retirement, leave of absence, lay-off, or employee becomes ineligible (except gross misconduct dismissal)	Subscriber and Dependents	Earliest of: 1. 18 months, or 2. Enrollment in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Divorce, marriage dissolution, or legal separation	Former spouse and any Dependent children who lose coverage	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Death of Subscriber	Surviving spouse and Dependent children	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Dependents lose eligibility due to Subscriber's entitlement to Medicare	Spouse and Dependents	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Subscriber's total disability	Subscriber and Dependents	Earliest of: 1. 29 months, or 2. Date total disability ends, or 3. Enrollment date in other group coverage or Medicare.
Retirees of employer filing Chapter 11 bankruptcy (includes substantial reduction in coverage within 1 year of filing)	Retiree and Dependents	Earliest of: 1. Enrollment date in other group coverage, or 2. Death of retiree or Dependent electing COBRA.

Surviving Dependents of retiree on lifetime continuation due to the bankruptcy of the employer	Surviving spouse and Dependents	Earliest of: 1. 36 months following retiree's death, or 2. Enrollment date in other group coverage.

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

1. Choosing Continuation

   If you lose coverage, your employer must notify you of the option to continue coverage within 14 days after employment ends. If coverage for your Dependent ends because of divorce, legal separation, or any other change in Dependent status, you or your covered Dependents must notify your employer within 60 days.

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

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

2. Second qualifying event

   If a second qualifying event occurs during continuation, a Dependent qualified beneficiary may be entitled to election rights of their own and an extended continuation period. This rule only applies when the initial qualifying event for continuation is the employee's termination of employment, retirement, leave of absence, layoff, or reduction of hours.

   When a second qualifying event occurs such as the death of the former covered employee, the Dependent must notify the employer of the second event within 30 days after it occurs in order to continue coverage. In no event will the first and second period of continuation extend beyond the earlier of the date coverage would otherwise terminate or 36 months.

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

3. Terminating Continuation of Coverage - COBRA

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

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

b) This Certificate is terminated by the Group Subscriber;

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

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

DENTAL PROVIDERS AND CLAIMS PAYMENT

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

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

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

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

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

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

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

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

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

PROVIDER NETWORK STATUS

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

Participating Dentists in California

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

Non-Participating Dentists

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

Unlike Participating Dentists, Non-Participating Dentists may send you a bill and collect for the amount of the Dentist's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Non-Participating Dentist charges. This amount may be significant. Choosing a Participating Dentist will likely result in lower out of pocket costs to you. Please call Customer Service Department at (844) 729-1565 for help in finding a Participating Dentist or visit Our website at www.anthem.com.

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

EMERGENCY CARE

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

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

PROVIDER DIRECTORIES

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

- Visit our website at www.anthem.com. Once you are on the website, click on Menu and then Find a Doctor. You can search as a Member using your Anthem ID card to make sure you find a Participating Dentist who accepts your plan; or
- Call our Customer Services Department at 800-627-0004. This number is also listed on your Identification Card.

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

TIMELY ACCESS TO CARE

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

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

If a Participating Dentist determines that the waiting time for an appointment can be extended without a detrimental impact on Your health, the Participating Dentist may schedule an appointment for a later time than noted above. Participating Dentists are required to have an answering service or a telephone answering machine during non-business hours, which will provide instructions on how you can obtain urgent or emergency care including, when applicable, how to contact another dentist who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

If you need the services of an interpreter, the services will be coordinated with scheduled appointments and will not result in a delay of your appointment.

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

ACCESS TO MEDICALLY APPROPRIATE CARE FROM A QUALIFIED PROVIDER

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

MEMBER COST SHARE

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

Payment of Benefits

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

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

THE MEMBER IS RESPONSIBLE FOR ALL TREATMENT CHARGES MADE BY A NON-PARTICIPATING DENTIST. WHEN SERVICES ARE OBTAINED FROM A NON-PARTICIPATING DENTIST, ANY BENEFITS PAYABLE UNDER THE GROUP CONTRACT ARE PAID DIRECTLY TO THE MEMBER UNLESS YOU ASSIGN THE PAYMENT DIRECTLY TO THE PROVIDER BY INDICATING SO ON THE CLAIM FORM.

Notice of Claim

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

Claim Forms

Anthem, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof

of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Such proof must include:

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

Claims should be submitted to:

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

Proof of Claim

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

Time of Payment of Claim

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

Payment of Claims

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

Explanation of Benefits

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

- total amounts charged for services/supplies received;
- the amount of the charges satisfied by your coverage;
- the amount for which you are responsible (if any);
- general information about your Appeals rights.

COVERED SERVICES

Dental Utilization Review

Dental utilization review is designed to promote the delivery of cost-effective dental care by encouraging the use of clinically recognized and proven procedures. It is included in your Plan to encourage you and your dentist to utilize your dental benefits in a cost-effective and clinically appropriate and recognized manner. Your right to benefits for Covered Services provided under this Plan is subject to review by licensed dentists who will apply certain policies, guidelines and limitations, including, but not limited to, our coverage/clinical guidelines, dental policy and utilization review features.

Dental utilization review is accomplished through pre-treatment review and retrospective review. Our dental coverage guidelines for pre-treatment review and retrospective review are intended to reflect general standards of care for dental practice applying state-specific regulations where necessary. The purpose of dental coverage guidelines is to assist in the interpretation of medical or dental necessity. In order to be expenses or services covered under this Plan, such expenses and services must meet Anthem's Medical or Dental Necessity requirements.

Pretreatment Estimate
(Estimate of Benefits)

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

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

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

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

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

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

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

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

Retrospective Review

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

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

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

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

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

PREVENTIVE CARE
(Diagnostic & Preventive Services)

Periodic, Comprehensive and Periodontal Oral Evaluations - Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

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

Limited, Detailed/Extensive and Problem Focused Evaluations - Covered 2 times per calendar year.

Radiographs (X-rays)

- **Bitewings** - Covered at 2 series of bitewings per calendar year.
- **Full Mouth (Complete Series) or Panoramic** - Covered 1 time per 36-month period.
- **Periapical(s)**
- **Occlusal**

Dental Cleaning

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

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

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

Fluoride Treatment

- Topical application of fluoride and fluoride varnish - Covered 2 times per calendar year.

EXCLUSIONS - Coverage is NOT provided for:

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

Basic Restorative Services

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

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

Composite (white) Resin Restorations

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

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

Basic Extractions

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

Space Maintainers - Covered 1 time per 60-month period on eligible Dependent children through the age of 12 for extracted primary posterior (back) teeth.

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

Brush Biopsy - Covered 1 time every 12 months.

Consultations - Covered 1 time per 12 month period.

Pin Retention - Covered 1 time per 60-month period.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered 1 time 36-month period for permanent first and second molars of eligible Dependent children through the age of 14.

EXCLUSIONS - Coverage is NOT provided for:

1. Case presentation of detailed treatment plans and office visits, during and after regularly scheduled hours, when no other services are performed.
2. Athletic mouthguard, enamel microabrasion, and odontoplasty.
3. Tooth whitening agents and tooth bonding.
4. Placement or removal of sedative filling, base or liner used under a restoration.
5. Pulp vitality tests.
6. Diagnostic casts.
7. Secondary diagnostic tests in addition to the primary therapy.
8. Amalgam or composite restorations placed for preventive purposes.

9. Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.
10. Analgesia, analgesia agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care.

Endodontic Services (Nerve or Pulp Treatment)

NON-SURGICAL ENDODONTIC SERVICES

Endodontic Therapy on Primary Teeth

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

Endodontic Therapy on Permanent Teeth

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

Endodontic Therapy on Primary or Permanent Teeth

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

Apexification - Covered 1 time per tooth per lifetime.

SURGICAL ENDODONTICS

Apicoectomy - Covered 1 time per tooth per 1 lifetime.

Retrograde Filling - Covered.

Root amputation - Covered.

Hemisection - Covered 1 time per tooth per lifetime.

EXCLUSIONS - Coverage is NOT provided for:

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

Periodontal Services (Gum & Bone Treatment)

NON-SURGICAL PERIODONTAL SERVICES

Periodontal Maintenance - A procedure that includes removal of bacteria from the gum pocket areas,

scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed previous surgical or nonsurgical periodontal treatment.

LIMITATION: Any combination of this procedure, and dental cleanings (see Diagnostic and Preventive section), Full Mouth Debridement and Scaling in the Presence of Moderate or Severe Gingival Inflammation is covered 2 times per calendar year.

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

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

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

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

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

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

SURGICAL PERIODONTAL SERVICES

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

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

- **Gingivectomy/gingivoplasty** - Covered 1 time per 24-month period.
- **Gingival flap** - Covered 1 time per 24-month period.
- **Osseous surgery** - Covered 1 time every 3 calendar years.
- **Bone replacement graft** - Covered 1 time every 3 calendar years.

LIMITATION: Complex surgical periodontal service is a benefit covered only if the pocket depth of the tooth is 5 millimeters or greater.

Apically positioned flap - Covered 1 time per tooth per 24 month period.

Guided tissue regeneration - Covered 1 time per tooth per 36-month period.

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

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

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

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

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

Crown lengthening - Covered 1 time every 3 calendar years.

Autogeneous connective tissue graft - Covered 2 times per tooth per 36-month period.

Non-Autogeneous connective graft - Covered 2 times per tooth per 36-month period.

EXCLUSIONS - Coverage is NOT provided for:

1. Bacteriologic tests for determination of periodontal disease or pathologic agents.
2. Provisional splinting, temporary procedures or interim stabilization of teeth.
3. Analgesia, analgesic agents, anxiolysis, inhalation of nitrous oxide or therapeutic drug injections, drugs, or medicaments for non-surgical and surgical periodontal care, regardless of the method of administration.

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

Complex Surgical Extractions

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

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

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

Frenulectomy (Frenectomy or Frenotomy)

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

LIMITATIONS

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

EXCLUSIONS - Coverage is NOT provided for:

1. Intravenous conscious sedation, IV sedation and general anesthesia when performed with Non-Surgical dental care.
2. Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration.
3. Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
4. Inpatient or outpatient hospital expenses.
5. Cytology sample collection – Collection of oral cytology sample via scraping of the oral mucosa.

Major Restorative Services- (Crowns, Inlays and Onlays)

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

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

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

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

Pre-fabricated Stainless Steel Crown - Covered 1 time per 60-month period.

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

Onlays and/or Permanent Crowns - Covered 1 time per 60-month period per tooth if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth.

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

Implant Crowns - See Prosthodontic Services.

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

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

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface - Covered 1 time per 60-month period when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

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

Veneers - Covered 1 time per 60-month period.

EXCLUSIONS - Coverage is NOT provided for:

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

Prosthodontic Services- (Dentures, Partials, and Bridges)

Tissue Conditioning - Covered 2 times per 12-month period.

Recement Fixed Prosthetic - Covered 1 time per 12 months.

Rebase - Covered 1 time per 24-month period:

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

Reline - Covered 2 times per 12 month period:

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

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

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

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

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

Partial and Bridge Adjustments - Covered 2 times per 12-month period:
- when the partial or bridge is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) - Covered 1 time per 60-month period:
- if 60 months have elapsed since the last benefited removable prosthetic appliance (denture or partial) and the existing denture or partial needs replacement because it cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) - Covered 1 time per 60-month period:
- if none of the individual units of the bridge has been benefited previously as a crown or cast restoration in the last 60 months; and
- if 60 months have elapsed since the last benefited removable prosthetic appliance (bridge) and the existing bridge needs replacement because it cannot be repaired or adjusted.

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

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

Single Tooth Implant Body, Abutment and Crown - Covered 1 time per 60-month period. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

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

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

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

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

EXCLUSIONS - Coverage is NOT provided for:

1. The replacement of an existing partial denture with a bridge.
2. Interim removable or fixed prosthetic appliances (dentures, partials or bridges).
3. Additional, elective or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments.

4. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
5. Placement or removal of sedative filling, base or liner used under a restoration.

Coverage shall be limited to the least expensive professionally acceptable treatment.

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

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

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

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

Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.

Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.

Cephalometric film

Oral/Facial Images

Other Complex Surgical Procedures

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

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

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

Benefit payments are made in equal amounts: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or until the lifetime maximum benefits are exhausted (see Benefit Maximums in the Summary of Benefits).

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

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

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

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

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

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

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

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

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

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

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

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

EXCLUSIONS

This section indicates items which are excluded and are not considered Covered Services. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services.

Coverage is NOT provided for:

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

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

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

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

e) Services of anesthesiologists.

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

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

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

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

j) Tooth whitening agents and tooth bonding.

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

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

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

n) Athletic mouth guards, enamel microabrasion and odontoplasty.

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

p) Bacteriologic tests.

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

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

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

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

u) Provisional splinting, temporary procedures or interim stabilization.

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

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

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

y) Any charges which exceed the Maximum Allowed Amount.

z) Pulp vitality tests.

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

bb) Diagnostic casts.

cc) Incomplete root canals.

dd) Anatomical crown exposure.

ee) Temporary anchorage devices.

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

gg) 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.

Limitations

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

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

Optional Treatment Plans

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

GENERAL PROVISIONS

Entire Contract; Changes

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

Time Limit on Certain Defenses

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

Grace Period

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

Reinstatement

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

Physical Examination and Autopsy

The insurer at its own expense shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of claim when and as often as it may reasonably require during the Pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

Legal Actions

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

Change of Beneficiary

The right to change of beneficiary is reserved to the insured employee, and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary.

Workers' Compensation Insurance

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

Relationship of Parties (Plan - Participating Dentists)

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

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

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

Not Liable for Provider Acts or Omissions

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

Identification Card

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

Circumstances Beyond the Control of the Plan

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

Reinstatement of Coverage for Members of the Military

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

Extension of Benefits

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

1. The installation of new appliances and modifications to appliances for which a master impression was made prior to the benefit termination date.
2. An installation of a crown, bridge, or cast restoration for which the tooth was prepared prior to the benefit termination date.

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

Continuation of Care After Termination of a Participating Dentist

Upon the termination of the contract or other agreement with any Participating Dentist, we shall be liable to pay the cost of Covered Services (other than any applicable deductible and coinsurance) rendered by that Participating Dentist to a Member who retains eligibility under this Certificate or by operation of law, and who is under the care of that Participating Dentist at the time of such termination, and that Participating Dentist shall continue to provide such services for treatment in progress to the Member in accordance with the terms of this Certificate, until the treatment in progress is completed, up to a maximum of 90 days unless reasonable and medically appropriate provision is made for the completion of treatment in progress by another Participating Dentist.

Coordination of Benefits

Special COB rules apply when you or members of your family have additional dental care coverage through other group dental plans, including:

- group insurance plans, including other Anthem plans;
- labor management trustee plans, union welfare plans, employer welfare plans, employer organization plans, or employee benefit organization plans; and
- coverage under any tax-supported or government program to the extent permitted by law.

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 group dental plan, one coverage will pay benefits first (be primary) and the other will pay second (be secondary). The primary coverage will pay benefits first. 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.

Definition of "other contract". Other contract means any arrangement providing dental care benefits or services through:

- group or blanket insurance coverage;
- group Anthem, health maintenance organization, and other prepayment coverage;
- coverage under labor management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; and
- coverage under any tax supported or government program to the extent permitted by law.

If there is more than one other contract, this provision will apply separately to each. If another contract 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 agreement and the other contract both provide that this agreement is primary, then this agreement is primary. When Anthem determines that this agreement is secondary under the rules described below, benefits will be coordinated so that our payment plus the other contract's payment will not exceed Anthem *maximum allowed amount* for *covered services*.

Order of Benefit Determination Rules

1. Pediatric Dental Coordination of Benefits (COB). If pediatric dental Essential Health Benefits are included as part of the medical plan, the medical plan will be the primary coverage and any standalone 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 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' contracts, the following will apply:
    a. The contract 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 contract will be primary.
        ii. If the parent with custody has remarried, that parent's contract will be primary and the stepparent's contract will be secondary. The benefits of the contract 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 contract 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 contract of the parent whose birthday occurs earlier in the calendar year will be primary.
7. If the other contract includes the gender rule, then that rule will be used instead of the rules listed above. The gender rule states that the father's contract will be primary for the children.
8. If there are situations not covered above, then the contract that has been in effect the longest period of time (without interruption) will be primary. There is an exception to this rule. The contract that covers a working employee (or his dependent) will be primary. The contract 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 contract has different rules from those listed above other than the gender rule, that contract 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 contract, Anthem may pay an entity (provider, other carrier, etc.) that has paid any amounts it determines will meet the intent of this provision. These amounts shall be deemed to be benefits paid under this agreement. Upon this payment, Anthem will no longer be liable under this agreement.

Relationship of Parties (Group-Member-Plan)

Neither the Group nor any Member is the agent or representative of the Plan.

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

Conformity with Law

Any provision of this Certificate which is in conflict with the laws of the state in which the Group Dental Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws. **Governing Law:** The laws of the State of California will be used to interpret any part of this Policy.

Modifications

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

Right of Recovery

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

CLAIM AND APPEAL PROCEDURES

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

Appeals

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

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

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

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

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

Authorized Representative

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

BINDING ARBITRATION

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this *plan* or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort, or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

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 *member* and the *plan administrator* agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The *member* and the *plan administrator* agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the *member* waives any right to pursue, on a class basis, any such controversy or claim against the *plan administrator* and the *plan administrator* waives any right to pursue on a class basis any such controversy or claim against the *member*.

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 begun by the *member* making written demand on the *plan administrator*. Any demand for arbitration must be made within one (1) year from the issuance by the *claims administrator* of its decision following appeal. In cases where the amount in controversy is within the jurisdiction of small claims court, suit must be filed within one (1) year from the issuance by the *claims administrator* of its decision following appeal. Failure to demand arbitration or file in small claims court within one (1) year of the issuance by the *claims administrator* of its decision following appeal shall result in the forfeiture of any right to arbitration or to take any other legal action. Any written demand should be sent to the *plan administrator* at the address shown below:

SISC III
P.O. Box 1847
Bakersfield, CA 93303-1847

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 *member* and the *plan administrator*, or by order of the court, if the *member* and the *plan administrator* cannot agree. The arbitration will be held at a time and location mutually agreeable to the member and the *plan administrator*.

Please send all Binding Arbitration demands in writing to:

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

ANTHEM DENTAL

FOR CLAIMS AND ELIGIBILITY
Anthem Dental Claims
P.O. Box 1115
Minneapolis, Minnesota 55440-1115
(844) 729-1565

FOR APPEALS
P.O. Box 1122
Minneapolis, Minnesota 55440-1122

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