



Dental Benefit Policy

Anthem Dental Prime for Individuals & Families

RIGHT TO CANCEL: You have 10 days from the date of delivery to examine this policy. If you are not satisfied, for any reason, with the terms of this policy, you may return it to us within those 10 days. Return to Anthem Blue Cross, P.O. Box 1115, Minneapolis, MN 55440-1115 by midnight on the tenth day. We will then issue a full refund of any premiums and fees paid, less any payments made for benefits on behalf of you or your dependents.

Plan A

Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

INTRODUCTION

This policy is a legal contract between you, the policyholder (“policyholder”, “you”, and “your”) and Anthem Blue Cross (“Anthem”, “we”, “us”, and “our”). This policy is governed by the laws of the State of California. By paying the first premium and accepting this policy, you agree to be bound by the terms of this policy.

We may arrange for others to provide certain administrative services on our behalf, including eligibility determination and premium billing. To ensure efficient administration of your benefits, you must cooperate with them in the performance of their duties.

We agree to provide coverage for benefits as set out in this Dental Benefit Policy.

READ YOUR POLICY CAREFULLY. The entire policy sets forth, in detail, the rights and obligations of both you and Anthem. It is therefore important that you read your entire policy carefully.

Thank you for choosing Anthem Blue Cross!



Pam Kehaly
President
Anthem Blue Cross

Administered by:
ANTHEM BLUE CROSS
Administrative Offices
P.O. Box 1115
Minneapolis, Minnesota 55440-1115
(877) 567-1804

TABLE OF CONTENTS

INTRODUCTION.....	2
SUMMARY OF DENTAL BENEFITS.....	4
DENTAL PROVIDERS AND CLAIMS PAYMENTS.....	5
PARTICIPATING DENTISTS	5
NON-PARTICIPATING DENTISTS	6
YOUR COST SHARE.....	6
PRETREATMENT ESTIMATES	6
DESCRIPTION OF COVERED SERVICES	8
EXCLUSIONS AND LIMITATIONS.....	10
ELIGIBILITY AND TERMINATION.....	13
WHO IS ELIGIBLE	13
TERMINATION	14
HOW TO FILE CLAIMS	16
HOW TO FILE AN APPEAL	17
BINDING ARBITRATION	18
DEPARTMENT OF INSURANCE	19
GENERAL POLICY PROVISIONS.....	20
CONTACT US	22

SUMMARY OF DENTAL BENEFITS

The Summary of Dental Benefits is a summary of the deductibles, waiting periods, coverage percentages and benefit maximums that apply when you receive covered services from a dentist. Please refer to the Description of Covered Services section of this policy for a more complete explanation of the specific services covered. All covered services are subject to the conditions, exclusions, limitations, terms and provisions of this policy, including any attachments or riders.

Coverage Year

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

Deductible

The deductible is the amount you must pay before we begin to pay for covered services. You have to meet your deductible every coverage year before we will pay for covered services.

Deductible Amount.....\$0.00 per covered person.

Waiting Periods

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

Type of Service

Waiting Period

Diagnostic and Preventive ServicesNone

Coverage Percentages

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

Type of Service	Participating Dentists	Non-Participating Dentists
Diagnostic & Preventive Services	100%	100%

Benefit Maximum

The benefit maximum is the dollar amount we will pay for covered services for each covered person per coverage year, subject to the coverage percentages identified above. If you do not reach your benefit maximum, any unused amount is not carried over to the next coverage year.

Benefit Maximum\$500.00 per covered person

DENTAL PROVIDERS AND CLAIMS PAYMENTS

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

We make payments only when the covered dental procedures have been completed. We may require additional information from you or your dentist before a claim can be considered complete and ready for processing. In order to properly process a claim, we may be required to add an administrative policy line to the claim. Duplicate claims previously processed will be denied.

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. The maximum allowed amount is the maximum amount of reimbursement we will pay for covered dental services. 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.

You will be required to pay a portion of the maximum allowed amount if you have not met your deductible or have a coverage percentage due. 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 dental care from a dentist, we will apply processing rules to the claim submitted for that dental care. These rules evaluate the claim information and, among other things, determine whether the provider submitted the claim with the correct dental procedure code(s). Applying these rules may affect the maximum allowed amount. For example, your dentist may 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 the single maximum allowed amount for the single procedure code rather than a separate maximum allowed amount for each billed procedure code.

Likewise, when multiple procedures are performed on the same day by the same dentist or another dentist, 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.

Participating Dentists

A participating dentist is a dentist who has signed a written provider service agreement agreeing to service the program identified in this policy. 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 if you have exhausted your coverage for the service, have not met your deductible, have a coverage percentage due, have received non-covered services, or have exceeded the dental benefit maximum as outlined in the Summary of Dental Benefits. Please call our Customer Service Department at (877) 567-1804 for help in finding a participating dentist or visit our website at www.anthem.com/mydentalvision.

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

Non-Participating Dentists

Dentists who have NOT signed a written provider service agreement agreeing to service the program identified in this policy 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 dentist fee schedule, 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 us, 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 the 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 (877) 567-1804 for help in finding a participating dentist or visit our website at www.anthem.com/mydentalvision.

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.

Your 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 coverage percentage). Your deductible, coverage percentage and out-of-pocket costs may vary depending on whether you received services from a participating or non-participating dentist. Specifically, you may pay higher out-of-pocket costs when using non-participating dentists. Please see the Summary of Dental Benefits in this policy for your cost share responsibilities and limitations, or call Customer Service to learn how this policy's benefits or cost share amounts may vary by the type of dentist you use.

Pretreatment Estimates

It is recommended, but not required, that a pretreatment estimate be submitted to us prior to treatment for major restorative, periodontal, or prosthodontic services. See the section Description of Covered Services for more information on these services.

The pretreatment estimate is a valuable tool for both you and your dentist. Submitting a pretreatment estimate allows you and the dentist to know what benefits are available to you before receiving dental

care. This process does not pre-authorize the treatment nor determine its appropriateness for your dental condition.

The pretreatment estimate is only an estimate. It does not guarantee we will pay for your dental care. Our final payment will be based on the claim that is submitted for your dental care.

If you would like a pretreatment estimate, tell your dentist. Your dentist will determine the dental care to be performed. You or your dentist should submit a claim form to us outlining the proposed care. We will determine if the proposed care is covered and estimate the maximum allowed amount. We will also estimate your cost share amount, such as any coverage percentages and deductibles. You are responsible to pay any deductibles, coverage percentages, or for any services not covered under this policy.

A statement will be sent to you and your dentist estimating the maximum allowed amount and your cost share amount. These estimates are based on your current coverage. Any change in your coverage or your eligibility will affect the final payment. If claims for any other dental care are submitted before the date you receive the proposed care, this may reduce our final payment, which will increase your cost share amount.

Before you receive dental care, be sure to ask your dentist if they have agreed to service this dental policy. This will help avoid any misunderstanding over the maximum allowed amount or your cost share amount.

DESCRIPTION OF COVERED SERVICES

The following services are covered when given by a licensed dentist and within the generally accepted standards of dental practice. Services not listed in this policy are not covered.

Diagnostic and Preventive Services

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.

Radiographs (X-rays)

- **Bitewings** - Covered at 1 series of bitewings per 12-month period for covered persons through the age of 17; 1 series of bitewings per 24-month period for covered persons age eighteen 18 and over.
- **Full Mouth (Complete Series) or Panoramic** - Covered 1 time per 60-month period.
- **Periapical(s)** - 4 single x-rays are covered per 12-month period.
- **Occlusal** - Covered at 2 series per 24-month period.

Dental Cleaning

- **Prophylaxis** - Any combination of this procedure and periodontal maintenance (See Periodontal Services) are covered 2 times per calendar year.

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

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

Fluoride Treatment (Topical application of fluoride or fluoride varnish) - Covered 1 time per 12-month period for dependent children through the age of 18.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered 1 time per 24-month period for permanent first and second molars of eligible dependent children through the age of 15.

Enhanced benefit for covered persons who are pregnant or who have diabetes

Enhanced dental benefits are available for covered persons who are pregnant or diagnosed with Type 1 or Type 2 diabetes. Covered persons diagnosed with gestational diabetes are eligible for benefits due to pregnancy or diabetes, but not both.

A covered person who is pregnant or diagnosed with gestational diabetes is eligible for one additional benefit for a maximum of two coverage years. A covered person diagnosed with Type 1 or Type 2 diabetes is eligible for one additional benefit per coverage year until their coverage ends. The enhanced benefits include a maximum of one of the following procedures:

- Prophylaxis-adult.

To obtain the additional benefit(s), the covered person must complete the enhanced benefit application enrollment form and submit it to us at:

Anthem Dental Claims
Attention: Clinical Integration Coordinator
P.O. Box 1115
Minneapolis, MN 55440-1115

The enhanced benefit will be available on the first of the month following the date we receive the enhanced benefit enrollment form.

EXCLUSIONS AND LIMITATIONS

Exclusions

We will not pay for services incurred for, or in connection with, any of the items below.

- Dental services which a covered person would be entitled to receive for a nominal charge or without charge if this policy were not in force under any Worker's Compensation Law, Federal Medicaid program, or Federal Veteran's Administration program. However, if a covered person receives a bill or direct charge for dental services under any governmental program, then this exclusion will not apply. Benefits under this policy will not be reduced or denied because dental services are rendered to a covered person who is eligible for or receiving medical assistance.
- Dental services or health care services not specifically covered under this policy (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).
- Dental 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.
- Dental services completed prior to the date the covered person became eligible for coverage.
- Services of anesthesiologists.
- 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.
- 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.
- Dental services that are not given by a licensed dentist, licensed physician, his or her employees.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Tooth whitening agents, tooth bonding and veneers.
- Orthodontic treatment services.
- Case presentations, office visits and consultations.
- Incomplete, interim or temporary services.
- Athletic mouth guards, enamel microabrasion and odontoplasty.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited.
- Procedures designed to enable prosthetic or restorative services to be performed, such as a crown lengthening.
- Bacteriologic tests.
- Cytology sample collection (the collection of oral cytology sample via scraping of the oral mucosa).
- Cysts and Tumors.
- Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
- Interim or temporary removable or fixed prosthetic appliances (dentures, partials or bridges).

- Services for the replacement of an existing partial denture with a bridge.
- Additional, elective or enhanced prosthodontic procedures including, connector bar(s), stress breakers and precision attachments.
- Provisional splinting, temporary procedures or interim stabilization.
- Placement or removal of sedative filling, base or liner used under a restoration.
- Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital or surgical center.
- Oral hygiene instruction.
- Occlusal procedures, including occlusal guards and adjustments.
- Any charges that exceed the maximum allowed amount.
- Pulp vitality tests.
- Secondary diagnostic tests in addition to the primary therapy.
- Diagnostic casts.
- Amalgam or composite restorations placed for preventive purposes.
- Incomplete root canals.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- 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.
- Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants.
- Implant maintenance or repair to an implant or implant abutment.
- Recement space maintainers.
- Brush Biopsy.
- Consultations.
- Basic Restorative Services.
- Endodontic Services.
- Periodontal Services.
- Oral Surgery Services.
- Major Restorative Services.
- Prosthodontic Services.
- Orthodontic services.

Limitations

- Optional Treatment Plans: If there is more than one treatment plan for your dental condition, the final decision on a treatment is between you and your dentist. We will cover the treatment that is the least costly. You will be responsible to pay for the difference in cost between the maximum allowed amount for the covered service and the optional treatment, plus any deductible and/or coverage percentage for the covered benefit.
- Dental orthodontic services not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this policy.

ELIGIBILITY AND TERMINATION

This section will tell you who is eligible for coverage under this policy and how to add or remove dependents from your policy. It will also give you information about how your coverage ends under this policy.

Who is Eligible

Policyholder

1. To be a policyholder, you must meet the following requirements:
 - a. be a California resident;
 - b. be at least 18 years of age;
 - c. have applied and been accepted for coverage; and
 - d. are not enrolled in any other group or individual dental coverage.

Dependents

The following dependents of a policyholder may be covered under this policy:

1. Spouse, meaning:
 - a. Married
 - b. Legally separated
2. Domestic Partner, as long as you and your domestic partner are in a legally registered and valid domestic partnership. All references to spouses in this policy will include domestic partners.
3. Dependent children up to the age of 26, including:
 - a. You and your spouse's natural-born and legally adopted children.
 - b. Children for whom you or your spouse are the legal guardian.
 - c. Stepchildren.
 - d. Grandchildren who are financially dependent on you and reside with you or your spouse continuously from birth.
4. Disabled children who have reached age 26 if:
 - a. they are primarily dependent upon you or your spouse;
 - b. they are incapable of self sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability; and
 - c. were disabled before they reached age 26.

Children may be added to the policy at the time the policyholder originally purchases the policy or may be added anytime up to 31 days following the child's 3rd birthday. If a child is born or adopted after the policyholder's original policy effective date, the child may be added anytime between birth (or date of adoption) and 31 days following the child's 3rd birthday. If the child is added within 31 days following the child's birth/adoption, coverage for the child will be effective on the date of the child's birth/adoption. If the child is not added within 31 days following their 3rd birthday, that child may be added only if there is a family status change, or at the next policy renewal date.

Family Status Change

Your benefit and enrollment elections are intended to remain the same until your next renewal date. Changes to your policy can only be made at your renewal date, unless you have a family status change. Events that qualify as a family status change are:

- Change in legal marital status such as marriage, divorce or dissolution of a domestic partnership.
- Change in number of dependents in the event of birth, adoption, a court order to provide coverage to a dependent child, or death.
- Change in your spouse's employment, such as starting or losing a job.
- Change in your spouse's work schedule, such as going from full-time to part-time or part-time to full-time, or beginning or ending an unpaid leave of absence.
- Covered child reaches age 26.

Due to federal regulations, the changes you make to your benefits must be consistent with the family status change event that you experience. For example, if you have a baby, it is consistent to add your newborn to your current dental coverage but it is not consistent to drop your dental coverage altogether.

If you experience one of the above eligible family status changes during the year, you have 31 days from the event to change your elections. If you need to make changes to your policy due to a family status change, you should contact Customer Service at the number listed on your ID Card to obtain an Enrollment Change Form.

Policy Effective Date

Your policy begins on the effective date stated on the Policy Confirmation that you received following your enrollment.

Termination

When Your Coverage Ends

Your coverage and that of your dependents will end on the earliest of the following dates:

1. The end of the month in which you are no longer eligible;
2. The end of the month in which your dependent is no longer a dependent as defined in this policy;
3. The last day of the month for which a premium has not been paid, subject to the grace period; or
4. The date the policy ends.

Cancelling Your Policy

After your initial 12 month policy period, you may terminate this policy by giving written notice to us 31 days prior to any premium due date. If you elect coverage and subsequently cancel your policy, you and your dependents will not be allowed to re-enroll in the policy for a period of 24 months from the date your policy was cancelled.

Renewability

This policy will continue as long as your premiums are paid, subject to the grace period. We reserve the right to terminate the policy, in whole or in part, at any policy renewal date by giving you written notice at least 31 days prior to the renewal date. Termination of the policy will result in loss of coverage for all covered persons. If the policy is terminated, the rights of the covered persons are limited to covered

services incurred before termination. Termination is without prejudice to any claim originating while the policy was in force.

Reinstatement

If your policy is terminated because you do not pay your premium within the grace period you may have it reinstated. Your policy will be reinstated if we, or an agent authorized by us, accept your premium payment after we have terminated your policy. If we accept your premium, we will not require an application to reinstate your policy.

However, we may ask for a new application to accept your premium and reinstate your policy. If we ask for a new application we will only re-instate your policy after we approve your application. We will notify you if we do not approve of your application within 45 days. If we do not notify you within 45 days after we received your application, it will be deemed approved.

If your policy is reinstated, only dental care received after the reinstated date will be covered. Your rights will be the same and will not change due to the reinstatement. We will apply the reinstated premium to the period for which the premium was not paid. However, we will not apply premium to any period over 60 days prior to reinstatement.

HOW TO FILE CLAIMS

A claim must be filed in order for us to pay for covered services. Most dentists will file your claim for you. If your dentist does not file the claim, you must file your claim with us. This section will tell you how to file a claim.

Notice of Claim

We must receive written notice of claim within 20 days from the date you received dental care. If it was not reasonably possible to send the notice within that time, send it to us as soon as is reasonably possible. Notice given to us, or an agent authorized by us, with information sufficient to identify you will meet the notice of claim requirements. If the notice does not include sufficient data we need to process the claim, the necessary data must be submitted to us within the time frames specified below or no benefits will be payable except as required by law.

Claim Forms

Many dentists will file the claim form for you. If the forms are not available, send us a notice of claim or contact Customer Service and ask for a claim form to be sent to you. The form will be sent to you within 15 days. After we receive a written notice of claim, we will give you any forms you need to file proof of claim. If we do not give you these forms within 15 days after you have filed your notice of claim, you will not have to use these forms. You may file proof of claim by sending us written proof of the occurrence, character, and the extent giving rise to the claim. Such proof must include:

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

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

Claims should be submitted to:

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

Proof of Claim

We must receive your written proofs of claim within 90 days after the date you received dental care. If proof of claim is not sent within that time, your claim will not be reduced or denied, as long as it was not possible to send your proof. However, you must send it as soon as reasonably possible. In any case, the proof of claim must be sent to us no later than 15 months after the date of service, unless you were legally incapacitated.

Time of Payment of Claim

Any payments for covered services will be made immediately upon receipt of proper written proof of claim together with any information necessary to determine our payment. Should loss of life occur, we will pay benefits to your designated beneficiary. If you have no designated beneficiary, we will pay benefits to your estate.

HOW TO FILE AN APPEAL

This section explains and offers instructions on what to do if you disagree with a denial or modification of benefits for a dental claim, or are dissatisfied with the dental treatment or a service rendered by either a dentist or by us, and wishes to file a grievance or appeal.

Grievances

If you are dissatisfied, you may file a grievance with us verbally or in writing. If you have a grievance about any aspect of our service, such as the processing of a dental claim, a benefit determination, or premium billing, or the dental treatment or services rendered by a dentist, you may contact our customer service department at the toll free number listed below or on your ID card.

Anthem Blue Cross
Attention: Appeals Unit
PO Box 1122
Minneapolis, MN 55440-1122

We will acknowledge receipt of the grievance and provide a resolution within the state's specified grievance resolution time frames. If you are not satisfied with the resolution of the grievance, an appeal may be filed as explained in the appeals section below:

Appeals

You may file an appeal verbally or in writing. We will acknowledge receipt of the appeal and provide a resolution within the state's specified appeal resolution time frames. An appeal may be filed for any dental claim that has been denied in whole or in part or to request a reconsideration for any adverse grievance decision. In the appeal, please state plainly the reason(s) why the treatment or service should not have been denied or why the adverse grievance decision should be reversed. All appeals will be reviewed by an individual not previously involved in the original decision. Reviews involving clinical judgment will be reviewed by a qualified clinical reviewer. Please include any documents or information that may have a bearing on our decision in our review but were not previously available to us.

Please send written appeals to the following address or contact us at the toll-free phone number listed below:

Anthem Blue Cross
Attention: Appeals Unit
PO Box 1122
Minneapolis, MN 55440-1122

You may designate a representative (e.g., the health care provider or anyone else of your choosing) to file a grievance or appeal on your behalf. We must receive a written designation before working with the representative.

The grievance and appeals process is governed by laws and regulations, and may be modified from time to time by us as those laws may require.

Both TTY/TDD services for the hearing and speech impaired and language translation assistance are available upon request to assist you in filing a grievance or appeal.

BINDING ARBITRATION

ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICES UNDER THE POLICY/PLAN OR ANY OTHER ISSUES RELATED TO THE POLICY/PLAN AND CLAIMS OF MEDICAL MALPRACTICE MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. It is understood that any dispute including disputes relating to the delivery of services under the policy or any other issues related to the policy including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. YOU AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL OR TO PARTICIPATE IN A CLASS ACTION IS WAIVED FOR BOTH DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE POLICY/PLAN OR ANY OTHER ISSUES RELATED TO THE POLICY/PLAN AND MEDICAL MALPRACTICE CLAIMS.

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

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

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

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

Please send all Binding Arbitration demands in writing to: Anthem Blue Cross, P.O. 659471, San Antonio Texas 78265.

Department of Insurance

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

Department of Insurance
Consumer Affairs Bureau
300 South Spring St., South Tower
Los Angeles, California 90013

Toll-free phone number (800) 927-HELP (4375)

GENERAL POLICY PROVISIONS

Premium Calculations and Payment

The payment of any premium will keep the coverage in force until the next premium due date, subject to the grace period provision of the policy.

Your premium amount, the premium payment schedule and the payment method is stated on the Policy Confirmation that you received following your enrollment.

We may change the premium for this policy by giving you a written notice of at least 60 days prior to the change.

For premium and payment questions, call (877) 567-1804.

Grace Period

You have a grace period of 31 days to pay your premium. Your coverage will continue during the grace period, subject to the terms and conditions of this policy.

Entire Contract; Changes

This policy, including any endorsements or attached papers, is the entire contract of insurance. Its terms can be changed only a written endorsement signed by one of our authorized officers. No agent or employee of ours is authorized to change the terms or waive any other the provisions of this policy.

Time Limit on Certain Defenses

After you have been insured under this policy for 2 consecutive years, we will not use any material misstatements you may have made in your application for this policy, except any fraudulent misstatements, to either void this policy or to deny a claim for any covered services incurred after the expiration of such 2 year period.

Legal Actions

No action at law or in equity will be brought to recover on this policy sooner than 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 3 years after the time written proof of loss is required to be furnished.

Conformity to Law

The laws of the State of California will be used to interpret any of this policy.

Clerical Error

Clerical error by us will not invalidate insurance otherwise validly in force nor continue insurance otherwise terminated.

Dental Examination

We have the right to have a dentist examine you, at our own expense, as often as is reasonably required while processing a claim under this policy. We also have the right to make an autopsy in the case of death, where it is not prohibited by law.

Change in Beneficiary

You can change your beneficiary at any time by giving us written notice. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

Continuation of Care

If a participating dentist's contract terminates with us, we shall continue to pay for covered services received from the dentist for 90 days if you are under their care. The dental provider will also provide you care for 90 days in accordance with this policy unless your care is assumed by another participating dentist. To request continuation of care, please contact customer service at the number listed at the end of this booklet.

CONTACT US

CUSTOMER SERVICE DEPARTMENT
(877) 567-1804

Hours: 8 a.m to 4:30 p.m Central Time
Monday - Friday

For claims and eligibility:

Anthem Blue Cross
P.O. Box 1115
Minneapolis, MN 55440-1115

Send your appeal to:

Anthem Blue Cross
Attention: Appeals Unit
P.O. Box 1122
Minneapolis, MN 55440-1122

Our website:

www.anthem.com