Anthem Blue Cross

Dear Individual Member,

We would like to welcome you to Anthem Blue Cross and extend our thanks for choosing our health plan.

This booklet provides a complete statement of all the benefits available to you. Please read it carefully to be sure you fully understand your benefits, coverage, limitations and exclusions. For your convenience, at the front of this Evidence of Coverage is a brief summary of the benefits provided by this booklet. This is only a summary; the agreement contains the exact terms and conditions of coverage.

Additionally, please keep this booklet in a convenient place so you may refer to it whenever you have a question about your coverage.

If you have any questions regarding your eligibility, claims status or your benefits under this Evidence of Coverage, please feel free to contact us at the telephone number or address listed on your I.D. card.

Thank you for choosing Anthem Blue Cross.

ANTHEM BLUE CROSS

Leslie A. Margolin
President
Anthem Blue Cross

Nancy L. Purcell
Corporate Secretary
Anthem Blue Cross

HEALTH PLAN BENEFITS AND COVERAGE MATRIX

CONTRACT CODE: ZE6N/ZE7N/ZE8N
DENTAL SELECTHMO PLAN

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

This is an overview of coverage. The Evidence of Coverage (EOC) contains the exact terms and conditions of coverage. You have a right to view the EOC prior to enrollment. To obtain a copy of the EOC, please call 800-333-0912.

Category	Services	Coverage	Your Co-Payment	Special Limitations/Exclusions
Annual Deductible	None	None	None	
Lifetime Maximums	None	None	None	
Professional Services	General Dentist Diagnostic	Office visit Initial oral examination Intraoral x-rays-complete series Panoramic film	$5.00 No charge No charge No charge	
	General Dentist Preventive	Prophylaxis-adult	No charge	First 2 treatments in 12 consecutive months. All additional treatments in 12 consecutive month period require $44 co-payment.
		Prophylaxis-child	No charge	First 2 treatments in 12 consecutive months. All additional treatments in 12 consecutive month period require $35 co-payment.
	General Dentist Restorative	Amalgam one surface, primary Amalgam one surface, permanent Resin composite one surface, anterior-permanent Resin composite one surface, posterior-permanent	No charge* - $46.00 No charge* - $54.00 No charge* - $70.00 $75.00	*Member must meet a six month waiting period before benefits are payable on ZE7N and ZE8N.
	General Dentist Endodontics*	Molar root canal therapy Apicoectomy – anterior Retrograde filling-per root	$459.00 $329.00 $ 83.00	*Teeth with questionable, guarded or poor prognosis are not covered for endodontic treatment. Plan will allow for observation or extraction and prosthetic replacement.
	General Dentist Periodontics	Periodontal scaling and root planing-per quadrant Osseous surgery-per quadrant**	No charge* - $101.00 $520.00	*Member must meet a six month waiting period before benefits are payable on ZE7N and ZE8N. **Teeth with questionable, guarded or poor prognosis are not covered for periodontal surgery. Plan will allow for observation or extraction and prosthetic replacement.
	General Dentist Prosthodontics	Space maintainer-fixed-unilateral Inlay-metallic-three surfaces Crown-porcelain fused to high noble metal Crown-full cast high noble metal Denture-complete maxillary or mandibular Denture-adjustment, complete maxillary or mandibular Partial denture-maxillary or mandibular	$145.00 $388.00 $432.00 $432.00 $577.00 $ 31.00 $430.00	

Category	Services	Coverage	Your Co-Payment	Limitations/Exclusions
Professional Services	General Dentist Oral Surgery	Extraction-single tooth Removal of impacted tooth-partially bony	No charge* - $ 60.00 $176.00	*Member must meet a six month waiting period before benefits are payable on ZE7N and ZE8N.
	Miscellaneous	General anesthesia-first 30 minutes Emergency palliative treatment	 $150.00* $ 52.00	*General anesthesia is covered under this dental contract if the member's medical contract does not cover.
	Orthodontic	Adults age 18 and over Children through age 17 Retention	$3045.00 $2870.00 $ 210.00	Myfunctional therapy and related services.
Outpatient Services		Not Applicable		
Hospitalization Services		Not Applicable		
Emergency Health Coverage		Not Applicable		
Ambulance Services		Not Applicable		
Prescription Drug Coverage		Not Applicable		
Durable Medical Equipment		Not Applicable		
Mental Health Services		Not Applicable		
Chemical Dependency Services		Not Applicable		
Home Health Services		Not Applicable		
Preventive Medicine for Women		Not Applicable		

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INDIVIDUAL
ZE7N
ANTHEM BLUE CROSS DENTAL SELECTHMO

ISSUED BY

ANTHEM BLUE CROSS

In this Agreement, "we," "us" and "our" mean Anthem Blue Cross ("Anthem"). You are the eligible Subscriber whose Enrollment Application has been accepted by us. "You" and "your" also mean any eligible Family Members who were listed on your Enrollment Application and accepted by us for coverage under this Agreement. When we use the word "Member" in this Agreement, we mean you and any eligible Family Members who are covered under this Agreement.

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

YOU HAVE THE RIGHT TO VIEW THE EOC PRIOR TO ENROLLMENT.

ANTHEM BLUE CROSS enters into this Agreement with you. In consideration for the payment of the Quarterly Subscription Charges stated in this Agreement, we will provide the services and benefits listed in this Agreement to you and your eligible Family Members.

THE BENEFITS OF THIS AGREEMENT ARE PROVIDED ONLY FOR SERVICES THAT ARE CONSIDERED DENTALLY NECESSARY BY ANTHEM BLUE CROSS. THE FACT THAT A DENTIST OR PHYSICIAN PRESCRIBES OR ORDERS THE SERVICE DOES NOT, IN ITSELF, MAKE IT DENTALLY NECESSARY OR A COVERED EXPENSE. CONSULT THIS AGREEMENT OR TELEPHONE US AT THE NUMBER SHOWN ON YOUR MEMBER IDENTIFICATION CARD IF YOU HAVE ANY QUESTIONS REGARDING WHETHER SERVICES ARE COVERED.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS DENTAL CARE MAY BE OBTAINED.

BECAUSE WE CARE ABOUT THE QUALITY OF SERVICE PROVIDED TO OUR CUSTOMERS, YOUR TELEPHONE CALL TO US MAY BE RANDOMLY OBSERVED OR RECORDED TO ENSURE THAT WE ARE ACHIEVING THAT GOAL.

PART I DEFINITIONS

Listed below are Definitions which contain the meanings of key terms used in this Agreement. Throughout this Agreement, the terms defined, printed in bold face below, will appear with the first letter of each word in capital letters. When you see these capitalized words, you should refer to these "Definitions." The "Definitions" are listed in alphabetical order.

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

B. **Anthem Blue Cross ("Anthem")** is a health care service plan. We are regulated by the California Department of Corporations.

C. **Child** is the Subscriber's child, stepchild, legally adopted child who meets all of the conditions of coverage described in the Part entitled ELIGIBILITY. A Child who is in the process of being adopted is considered a legally adopted child if Anthem Blue Cross receives legal evidence of the intent to adopt and the child is placed in the physical custody of the Subscriber for the purpose of adoption.

D. **Co-Payment** is the amount of payment indicated in the SCHEDULE OF CO-PAYMENTS FOR COVERED SERVICES and the SCHEDULE OF REDUCED FEE SERVICES. It is due and payable at the time of service by the Member to the dental office or other providers of care.

E. **Covered Expense** is the expense you incur for Covered Services, but not more than the maximum amounts stated in YOUR DENTAL BENEFITS section. Expense is incurred on the date you receive the service or supply for which the charge is made.

F. **Covered Services** is any dental service received by you for which benefits would be payable in accordance with all terms, conditions, limitations, exclusions and other provisions of this Agreement.

G. **Dentally Necessary** procedures, supplies, equipment or services are those that we determine to be:

1. Appropriate for the symptoms, diagnosis or treatment of the dental condition, and

2. Provided for the diagnosis or direct care and treatment of the dental condition, and

3. Within standards of good dental practice within the organized dental community, and

4. Not primarily for the convenience of the Member's Dentist or Physician or another provider, and

5. The most appropriate procedures, supplies, equipment or service which can safely be provided. The most appropriate procedures, supplies, equipment or service must satisfy the following criteria: (i) there must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the Member with the particular dental condition being treated than other alternatives; and (ii) generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable.

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

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

J. **Emergency Services** are services provided in connection with the initial treatment of an emergency, which is defined as services required for alleviation of severe pain or bleeding and/or immediate diagnosis and treatment of an unforeseen condition. Emergency Services are not for continuing any treatment plan currently in process, unless it has been authorized. Final determination as to whether services were rendered in connection with an emergency will rest solely with Anthem Blue Cross.

K. **Enrollment Area** (service area) is defined as the geographical area within a 35 mile radius of the dental office selected by the Subscriber.

L. **Experimental Procedures** are those that are mainly limited to laboratory and/or animal research, but which are not generally accepted as proven and effective procedures within the organized dental community.

M. **Family Member** is the Subscriber's enrolled Spouse and each enrolled Child.

N. **Investigative Procedures** are those that have progressed to limited use on humans, but which are not generally accepted as proven and effective procedures within the organized dental community.

O. **Member** shall mean both the Subscriber and Family Members who are enrolled for coverage under this Agreement.

P. **Non-Participating Dentist** is a Dentist who has not entered into a Participating Anthem Blue Cross Dental SelectHMO Agreement with Anthem Blue Cross at the time services are rendered.

Q. Your **Participating Dental Office** is that dental office which will provide the general dental care you are entitled to under this Agreement. It is also referred to as the "Participating Dental Office" because it is a Dentist or a group of Dentists, organized as a legal entity, having an agreement in effect with Anthem Blue Cross to furnish dental care to Members, and which has been selected by the Subscriber to provide the services covered under this Agreement.

R. Your **Participating Dentist** refers to the Dentist from the staff of your Participating Dental Office to be the primary provider of your dental care while you are enrolled as an Anthem Blue Cross Dental SelectHMO Member in that Participating Dental Office. This is also referred to as the Participating Dentist because he or she is a licensed Dentist at a Participating Dental Office which has an agreement in effect with Anthem Blue Cross to furnish dental care to Anthem Blue Cross Dental SelectHMO Members.

S. **Participating Orthodontic Office** is that dental office which provides orthodontic services you are entitled to under this Agreement. All Participating Orthodontic Offices have a contract in effect with Anthem Blue Cross to provide orthodontic services to Anthem Blue Cross Dental SelectHMO Members.

T. **Participating Orthodontist** is a licensed Dentist (orthodontist) who has completed an advanced education program at an institution accredited by the American Dental Association, or American Orthodontic Association, or who has a practice limited to providing orthodontic services and has contracted with Anthem Blue Cross to provide orthodontic services to Members, and is an owner, associate or employee of the Participating Orthodontic Office.

U. **Participating Specialist** is a licensed Dentist who has completed an advanced education program at an institution accredited by the American Dental Association, or Government entity, or who has a practice limited to providing specialty services, and has contracted with Anthem Blue Cross to provide specialty services to Members, and is an owner, associate or employee of the Participating Specialty Office.

V. **Participating Specialty Office** is that dental office which provides specialty services you are entitled to under this Agreement. All Participating Specialty Offices have a contract in effect with Anthem Blue Cross to provide specialty services to Anthem Blue Cross Dental SelectHMO Members.

W. A **Physician or Surgeon** is one who is duly licensed (1) to prescribe and administer drugs, and (2) to perform surgery within the scope of his/her license.

X. **Reduced Fee Services** are dental services offered to Members at reduced fees by Participating Dentists and Participating Specialists.

Y. **Spouse** is the Subscriber's spouse under a marriage which is recognized as legally valid in the state of California between persons of the opposite sex.

Z. **Subscriber** is the person whose enrollment application has been accepted by us for coverage under this Agreement.

AA. **We** (us, our) refers to Anthem Blue Cross.

BB. A **Year** is a 12-month period starting January l at 12:01 a.m. Pacific Standard Time.

CC. **You** (your) refers to the Subscriber and Family Members of the Subscriber who are enrolled for benefits under this Agreement.

PART II ELIGIBILITY

A. Who is Eligible for Coverage

1. The **Subscriber** is the person listed as the applicant whose Individual Enrollment Application has been approved and accepted by us for coverage under this Agreement.

2. **Family Members** are the following members of the Subscriber's family who are eligible and accepted under this Agreement.

   a. The Subscriber's lawful Spouse of the opposite sex.

   b. Any unmarried children of the Subscriber or the Subscriber's enrolled Spouse who are under age 19; and

   c. Any unmarried children of the Subscriber or the enrolled Spouse who are between the ages of 19 and their 23rd birthday, provided they are dependent upon them for at least half of their support; and

   d. Any of the Subscriber's or enrolled Spouse's children who continue to be both incapable of self support due to continuing mental retardation or physical handicap and who are still at least one-half dependent upon the Subscriber or the enrolled Spouse for support. We must receive written proof of such handicap and dependency within 31 days of the Child reaching the limiting age and as often as we require thereafter. Two years after receipt of the initial proof, we may require no more than annual proof of the continuing handicap and dependency.

   e. A Child being adopted by the Subscriber will have coverage up to 31 days from the date on which the adoptive Child's birth parent or appropriate legal authority signs a written document granting the Subscriber or the enrolled Spouse the right to control health care for the adoptive Child, or absent this document, the date on which other evidence exists of this right. TO CONTINUE COVERAGE, THE ADOPTED CHILD MUST BE ENROLLED AS A FAMILY MEMBER BY NOTIFYING US IN WRITING WITHIN 60 DAYS OF THE DATE THE SUBSCRIBER'S AUTHORITY TO CONTROL THE CHILD'S HEALTH CARE IS GRANTED AND THE SUBSCRIBER WILL BE RESPONSIBLE FOR ANY ADDITIONAL SUBSCRIPTION CHARGES DUE EFFECTIVE FROM THE DATE THE SUBSCRIBER'S AUTHORITY TO CONTROL THE CHILD'S HEALTH CARE IS GRANTED.

3. If you voluntarily choose to disenroll from coverage under this *plan*, you must wait 14 months.

B. When the Member Becomes Ineligible.

A Member becomes ineligible for coverage under this Agreement when:

1. The Subscriber does not pay the subscription charges when due subject to the grace period.

2. Upon establishment of residence 35 miles or more from any Participating Dental Office.

3. The Spouse in no longer married to the Subscriber.

4. The Child fails to meet the eligibility rules listed above.

5. The Member becomes enrolled under any other Anthem Blue Cross Non-group dental Agreement.

6. When any misrepresentation is discovered on an application or health statement.

7. When an act of fraud has been committed.

8. When a Member fails or refuses to make Co-Payments at the time services are rendered.

9. When a Member interferes with the normal operations of the Dental office.

10. When a Member uses threatening or aggressive language.

11. When a Member refuses to follow a prescribed course of treatment and the Dentist believes that no professionally acceptable alternative exists, the Member will be advised. If the Member continues to refuse to follow the prescribed course of treatment, that Member's coverage will be cancelled.

C. **Notice of Ineligibility**

You must notify us of all changes affecting any Member's eligibility under this Agreement.

PART III TERM OF YOUR AGREEMENT

A. The Effective Date of your coverage is printed on your identification card.

B. Your coverage will stay in effect with our consent, on a three-month basis if you have chosen quarterly coverage, or on a two-month basis if you have chosen bi-monthly coverage, or on a monthly basis if you have chosen the Anthem Blue Cross monthly checking account deduction program.

C. Anthem Blue Cross may terminate, cancel or decline to renew this Agreement in the event of any of the following:

1. The Subscriber's failure to pay subscription charges as described below:

   If you fail to pay subscription charges as they become due, Anthem Blue Cross may terminate this Agreement as of the last day of the month currently paid through. Nevertheless, Anthem Blue Cross will terminate this Agreement only upon first giving you a written Notice of Cancellation at least fifteen (15) days prior to that termination. The Notice of Cancellation shall state that this Agreement shall not be terminated if you make appropriate payment in full within fifteen (15) days after Anthem Blue Cross issues the Notice of Cancellation.

   The Notice of Cancellation also shall inform you that, if this Agreement is terminated for nonpayment and you wish to apply for reinstatement, you shall be required to submit a new application for coverage, and that Anthem Blue Cross either may decline to permit reinstatement in Anthem Blue Cross' sole discretion or may permit reinstatement upon such terms and conditions as Anthem Blue Cross shall determine appropriate in its sole discretion;

2. Upon the return or dishonor by the bank of the third check for payment of subscription charges in any twelve month period for any reason.

3. Your fraud or deception in the use of services or facilities of Anthem Blue Cross, or your knowingly permitting such fraud or deception by another, including without limitation, any Member.

4. If the Member's Dentist is unable to provide professionally acceptable dental care due to the breakdown of the patient-physician relationship.

5. If the Member does not make co-payments due under this Agreement after the provider bills the Member or otherwise requests payment of the co-payment.

6. If the Member repeatedly acts in such a threatening, disruptive or abrasive manner as to prevent the effective operation of the Dental Group's dental offices.

7. The occurrence of any other event permitting termination, cancellation or nonrenewal described below.

   Anthem Blue Cross may terminate, cancel or decline to renew this Agreement when required to effectuate the purposes of the Knox-Keene Health Care Service Plan Act of 1975, with the consent of the California Commissioner of Corporations. Additionally, in the event of (i) an amendment to the Knox-Keene Act, or a change in the applicable interpretations thereof, which expands the basis upon which a health plan may terminate, cancel or decline to renew individual subscriber Agreements or (ii) the approval by the California Commissioner of Corporations of good causes for termination, cancellation or nonrenewal of an individual subscriber agreement of Anthem Blue Cross, other than as set forth in this Agreement, Anthem Blue Cross, may incorporate into this Agreement any of the bases for termination, cancellation or nonrenewal described in items (i) and (ii) above upon thirty-one (31) days prior written notice to you.

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

9. Upon becoming ineligible for this coverage (please see Part II, Section B.)

D. We have the right to modify this Agreement, including change subscription charges, if we give you 30 days' written notice.

   1. We will not modify this Agreement under this paragraph D on an individual basis, but only for all Members in the same class and covered under the same plan as you.

   2. The modification will take effect on the date listed in the notice.

E. If this Agreement is terminated for any cause any subscription charges received by Anthem Blue Cross for periods occurring after the effective date of that termination, less any amounts due to Anthem Blue Cross, will be refunded to you, and Anthem Blue Cross shall have no further liability or responsibility with regard to any Members under this Agreement. If the termination is for any reason other than your or a Family Members' fraud or deception in the use of services or facilities of Anthem Blue Cross (or knowingly permitting such fraud or deception by another), Anthem Blue Cross will make this refund to you within thirty (30) days.

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

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

Anthem Blue Cross
Anthem Blue Cross Dental SelectHMO
P.O. Box 6666
Oxnard, California 93031-6666

NOTE: Cancellation for cause is subject to the Grievance Procedure.

PART IV YOUR DENTAL BENEFITS

A. BASIC FACTS

We agree to furnish to you the dental benefits explained in this Agreement and any endorsements thereto, subject to the terms and conditions of the Agreement. These benefits are available to you provided that services are rendered or coordinated by your Participating Dentist, your Participating Dental Office and/or Anthem Blue Cross.

1. What is Anthem Blue Cross Dental SelectHMO?

Anthem Blue Cross Dental SelectHMO is a statewide dental program developed by Anthem Blue Cross. It consists of a network of dental offices and dental professionals who have contracted with us to provide you with the wide range of dental services for which you are entitled to benefits under this Agreement and other services at a reduced fee. From these many providers, you choose the dental office that will thereafter provide your dental care.

2. Your ID Card

Your key to Anthem Blue Cross Dental SelectHMO is your identification card. Besides identifying you, this card indicates the Participating Dental Office in which you are enrolled and provides its address and telephone number. Be sure to keep this card with you and to present it whenever you are requested to do so.

3. Choosing a Dental Office and Dentist

Upon enrollment, each Subscriber must choose an Anthem Blue Cross Dental SelectHMO Participating Dental Office. Your Participating Dentist will diagnose and treat most of your dental conditions and will coordinate all your dental care. Anthem Blue Cross has made arrangements with Participating Dental Offices to provide certain dental services that are not Covered Services to you at a reduced fee. These fees are set forth in this Agreement in the Part entitled SCHEDULE OF REDUCED FEE SERVICES.

All Members of the Family must be seen in the same Participating Anthem Blue Cross Dental SelectHMO Office. We urge you to develop a close relationship with your Participating Dentist and to follow his or her advice carefully.

4. Choosing a Participating Specialty Office and Specialty Dentist

When it is determined that you require specialty care, you may select a Participating Specialty Office and Participating Specialist by consulting your Participating Dentist or by calling(888) 209-7852. Anthem Blue Cross has made arrangements with Participating Specialty Offices to provide specialty services to you at a reduced fee. These fees are set forth in this Agreement in the Part entitled SCHEDULE OF REDUCED FEE SERVICES.

5. **Changing Participating Dental Offices** (This applies to Participating Dental Offices only, not to Participating Specialty Offices which can be selected with the help of your Participating Dentist when needed.)

Requests by the Member

There are two ways you can change Participating Dental Offices:

a. When you move your residence. If you do move, you must notify Anthem Blue Cross in writing and request a transfer to another Participating Dental Office that is located within 35 miles of your new residence.

b. Under special circumstances, you can request a transfer. Anthem Blue Cross must approve your request for the transfer to become effective.

NOTE: Transfers may not be authorized if you or any Family Member has an outstanding balance at the Participating Dental Office.

IF A TRANSFER OCCURS, ALL FAMILY MEMBERS WILL BE REQUIRED TO TRANSFER ENROLLMENT TO THE NEW PARTICIPATING DENTAL OFFICE.

Request by the Participating Dental Office

If a Participating Dental Office requests a Member's enrollment to be transferred, it will be considered based upon the nature of the request. If the request is due to a Member's abusive language, behavior or lack of cooperation displayed in the dental office, a transfer may not occur and instead Anthem Blue Cross may request the Member's Anthem Blue Cross Dental SelectHMO coverage to be terminated as indicated under the Part entitled ELIGIBILITY.

B. HOW TO OBTAIN CARE

The procedures you follow to obtain care depend on the type of care you need: general care, specialty referral care, or emergency care.

1. **General Care**

Your Participating Dentist is the first person you should consult for dental care. He or she is responsible for providing you with general dental care and can help determine when you need to see a specialist.

To make an appointment with your Participating Dentist, call your Participating Dental Office. (Please call in advance, especially if specific days or times are desired.) When you call, IDENTIFY YOURSELF AS AN ANTHEM BLUE CROSS DENTAL SELECTHMO MEMBER and have the following information from your identification card available:

- your name
- the certificate number on your ID card. (This is usually your social security number.)
- the group number from your ID card.
- the name of your Participating Dentist. (If you have not selected a dentist, your Participating Dental Office will help you.)
- a brief explanation of your symptoms, if any.

Your Participating Dental Office will then schedule an appointment for you or otherwise arrange for appropriate care.

When you come in for your appointment, you will be asked to show your Athem Blue Cross Dental SelectHMO identification card. Since you must have this card to receive your Anthem Blue Cross Dental SelectHMO benefits, be sure to have it with you.

Upon your first visit to your Participating Dental Office, it is most common to expect an examination, x-rays and treatment evaluation only. Subsequent appointments for follow-up treatment are scheduled based upon this evaluation and those procedures requiring more immediate attention.

If you need to cancel or reschedule an appointment, please notify your Participating Dental Office as far in advance as possible. This courtesy may allow your Participating Dental Office to accommodate another person in need of dental treatment. Your Participating Dental Office will charge you a $20 charge if you fail to cancel an appointment or give less than 24 hours notice that you do not intend to keep a scheduled appointment. This charge is **not** reimbursable by Anthem Blue Cross.

2. **Specialty Referral Care**

Your Participating Dental Office is responsible for providing all Covered Services, subject to any applicable Member Co-Payments, as listed in the PART entitled SCHEDULE OF CO-PAYMENTS FOR COVERED SERVICES. However, certain dental services may be eligible for referral to a specialist. Your Participating Dentist can help determine when you need to see a specialist.

If you need or would like to receive specialty services, you should contact the Participating Specialty Office to arrange for an appointment. The specialty office will schedule an examination appointment. After evaluation of the services to be performed the specialty office will schedule your next appointment to begin the specialty services.

Anthem Blue Cross has made arrangements with Participating Specialty Offices to provide specialty services to you at a reduced fee. These fees are set forth in this Agreement in the PART entitled SCHEDULE OF REDUCED FEE SERVICES. You are responsible for all applicable Co-Payments which are to be paid to the Participating Specialists at the time the services are provided.

Second Opinion Policy

Anthem Blue Cross Dental SelectHMO Members are entitled to a second dental opinion when the Member's primary care dentist or specialist has recommended a treatment to the Member and the Member wishes another opinion.

The Member is entitled to the second opinion with a different primary care dentist or appropriate specialist who contracts with Anthem Blue Cross Dental SelectHMO. The Member should request a second dental opinion through the Anthem Blue Cross Dental SelectHMO Member Services Department. The request will be handled in accordance with written and established Anthem Blue Cross Dental SelectHMO policies.

The Member may appeal a denial for a second dental opinion to: Anthem Blue Cross Dental SelectHMO Grievance Committee, P.O. Box 9066, Oxnard, CA 93031-9066.

The appeal will be reviewed through the plan's grievance process on the basis of the necessity of the treatment and/or specialty procedure being recommended. Appeals are reviewed on the basis of all available dental records and the input of the referring dentist or specialist. All appeals for the necessity of a second opinion are reviewed by a dentist having appropriate clinical background, as determined by the Dental Director.

3. **Emergency Care**

Emergency Services are dental services provided for the initial treatment for alleviation of severe pain or bleeding and/or immediate diagnosis and treatment of an unforeseen dental condition. Emergency Services are not for continuing any treatment plan currently in process, unless it has been authorized. While it is intended that all services, including Emergency Services, are to be provided by your Participating Dental Office, we recognize that special circumstances may exist which prevent you from receiving emergency dental treatment from your Participating Dental Office. This Agreement provides benefits for two different types of Emergency Services situations which are described below. You are responsible for any applicable Co-Payments regardless of who provided the Emergency Services.

Outside the Enrollment Area

If you are temporarily more than 35 miles from your Participating Dental Office and you need emergency dental care, you may obtain care from any Dentist. You will have to pay for such Emergency Services; however, upon submission of an itemized paid receipt of the Emergency Services rendered, Anthem Blue Cross will reimburse you up to a maximum of $50.00, less any applicable Co-Payments for the procedures performed. If you present an itemized statement from a dental office which is located within 35 miles of your Participating Dental Office, you will **NOT** be reimbursed for that expense.

Within the Enrollment Area

If you are within the Enrollment Area of your Participating Dental Office, you must obtain care from that office.

C. WHAT'S COVERED

The wide range of dental benefits available to you under this Agreement are listed in detail in the PART entitled SCHEDULE OF CO-PAYMENTS FOR COVERED SERVICES. What follows is a brief description of how the benefits of this Agreement work.

1. Co-Payments

Some services are provided to you free of charge. For certain other services, you are required to pay a Co-Payment amount at the time the services are provided. These Co-Payments are specified in the PART entitled SCHEDULE OF CO-PAYMENTS FOR COVERED SERVICES.

2. Types of Services

The following is a brief overview of the dental services available to you under this Agreement. For a more detailed listing, refer to the PART entitled SCHEDULE OF CO-PAYMENTS FOR COVERED SERVICES.

Diagnostic: Diagnostic services are routine services to determine the type of treatment you may need.

Preventive: Preventive services are performed to help prevent certain conditions from occurring.

Restorative: Restorative services are performed to restore tooth structure lost as a result of dental decay.

Endodontics: Endodontic services such as root canal therapy are performed to treat diseases of the tooth pulp, nerve and associated structures.

Periodontics: Periodontic services are performed to treat diseases of the gums and supporting structures.

Removable Prosthodontics: Removable prosthodontic services are performed to replace missing teeth with full or partial dentures.

Fixed Prosthodontics: Fixed prosthodontic services are performed to repair tooth structure lost due to dental decay or replace missing teeth with bridges.

Oral Surgery: Oral surgery is performed when you require surgical procedures involving the teeth, bone and gums associated with the teeth.

3. **When Dental Procedures Start**

A dental procedure is considered started when the actual performance of the procedure starts, except that:

- for fixed bridgework and full or partial dentures, it starts when the first impressions are taken and/or abutment teeth are prepared, or

- for crowns, inlay or onlay, it starts on the first date of preparation of the tooth involved, or

- for root canal therapy, it starts when the pulp chamber of the tooth is opened.

PART V SCHEDULE OF CO-PAYMENTS FOR COVERED SERVICES

The services which are provided for the treatment of covered dental benefits are listed below. Included in the list of Covered Services are the Co-Payment amounts you will be required to pay for certain services when rendered by a Participating Dental Office. All services are subject to the EXCLUSIONS AND LIMITATIONS of this Agreement.

DIAGNOSTIC

These are routine services which are required by your Dentist to determine the type of treatment you may need.

COVERED SERVICES – These co-payments apply to services rendered by a Participating Dental Office only. Specialty services are covered on a separate list in this booklet.

Clinical Oral Examinations

All office visits	$5.00
Initial oral examination	No Charge
Periodic oral examination	No Charge
Emergency oral examination	No Charge

X-Rays

Intraoral-complete series	No Charge
Intraoral-periapical-first film	No Charge
Intraoral-periapical-each additional film	No Charge
Intraoral-occlusal film	No Charge
Bitewing-single film	No Charge
Bitewings-two films	No Charge
Bitewings-four films	No Charge
Panoramic film	No Charge

Tests

Pulp vitality tests	No Charge

PREVENTIVE

These services are performed by your Dentist or a licensed dental hygienist to help prevent certain conditions from occurring.

Dental Prophylaxis

Prophylaxis-adult	No Charge**
Prophylaxis-child	No Charge***

**First 2 treatments in 12 consecutive months. All additional treatments in 12 consecutive month period require a $44 co-payment.
***First 2 treatments in 12 consecutive months. All additional treatments in 12 consecutive month period require a $35 co-payment.

Topical Fluoride Treatment

Topical application of fluoride (including prophylaxis)-child..... No Charge
Topical application of fluoride (excluding prophylaxis)-child..... No Charge

Other Preventive Services

Dietary planning for the control of dental caries ..... No Charge
Oral hygiene instruction..... No Charge

RESTORATIVE

These services are performed by your Dentist to restore tooth structure lost as a result of dental decay.

Amalgam Restorations (including polishing)

One surface, primary..... No Charge*
Two surfaces, primary ..... No Charge*
Three surfaces, primary ..... No Charge*
One surface, permanent ..... No Charge*
Two surfaces, permanent ..... No Charge*
Three surfaces, permanent ..... No Charge*
Four or more surfaces, permanent ..... No Charge*

***You must meet a six month waiting period before these benefits are payable.**

Resin or Composite Restorations

Resin one surface, anterior-permanent ..... No Charge*
Resin two surfaces, anterior-permanent..... No Charge*
Resin three surfaces, anterior-permanent..... No Charge*

PART VI SCHEDULE OF REDUCED FEE SERVICES

The services which are available from Participating Dentists and Participating Specialists at a reduced fee are listed below. Included in the list of Reduced Fee Services are the Co-Payment amounts you will be required to pay for these services.

Note: There are two co-payment schedules. The first applies to Reduced Fee Services rendered by Participating Dental Offices only. The second applies to Reduced Fee Services obtained through a Participating Specialty Office. As a result, some procedures may be listed on both schedules with different fees. This is a PARTIAL list of Reduced Fee Services. A complete list is available by calling (888) 209-7852.

SAMPLE OF REDUCED FEE SERVICES BY PARTICIPATING DENTAL OFFICE

These co-payments apply to services rendered by a Participating Dental Office only. Specialty services are covered on a separate list in this booklet.

DIAGNOSTIC

These are routine services which are required by your Dentist to determine the type of treatment you may need.

	Co-payment
Consultations	
Consultation-per session	$46.00

PREVENTIVE

These services are performed by your Dentist or a licensed dental hygienist to help prevent certain conditions from occurring.

Other Preventive Services	
Sealant -per tooth	$25.00

RESTORATIVE

These services are performed by your Dentist to restore tooth structure lost as a result of dental decay.

Resin Composite Restorations	
Resin one surface, posterior-permanent	$75.00
Resin two surfaces, posterior-permanent	$102.00
Resin three surfaces, posterior-permanent	$124.00
Labial veneer (laminate)-chairside	$187.00

Other Restorative Services

Prefabricated stainless steel crown - primary tooth $106.00
Prefabricated stainless steel crown - permanent tooth $114.00
Prefabricated resin crown $114.00
Sedative filling $38.00
Crown buildup, including any pins $98.00
Pin retention-per tooth, in addition to restoration $31.00

ENDODONTICS

These services are performed by your Dentist to treat diseases of the tooth pulp nerve and their associated structures.

Pulp Capping

Pulp cap-direct $32.00
Pulp cap-indirect $41.00

Pulpotomy

Therapeutic pulpotomy $62.00

Root Canal Therapy (including treatment plan. clinical procedures, and follow-up care)

Anterior (excluding final restoration) $289.00
Bicuspid (excluding final restoration) $341.00
Molar (excluding final restoration) $459.00

Periapical Services

Apicoectomy periradicular surgery-anterior $329.00
Apicoectomy periradicular surgery-bicuspid $389.00
Retrograde filling-per root $83.00

PERIODONTICS

These services are performed by your Dentist or a licensed dental hygienist to treat diseases of the gums and supporting structures.

Surgical Services (including usual postoperative services)

Gingivectomy or gingivoplasty-per quadrant $194.00
Gingivectomy or gingivoplasty per tooth $72.00
Gingival curettage-per quadrant $100.00
Osseous surgery-per quadrant $520.00

Adjunctive Periodontal Services

Perio scaling and root planning-per quadrant $101.00

PROSTHODONTICS

These services are performed by your Dentist to repair tooth structure lost as a result of dental decay or replace missing teeth with full or partial dentures, crowns and bridges.

Space Maintenance (passive appliances)

Space maintainer-fixed-unilateral	$145.00
Space maintainer-fixed-bilateral	$212.00
Space maintainer-removable-unilateral	$195.00
Space maintainer-removable-bilateral	$231.00
Recement of space maintainer	$26.00

Inlay Restorations

Inlay-metallic-two surfaces	$349.00
Inlay metallic-three surfaces	$388.00

Crowns-Single Restoration Only

Crown-resin (laboratory)	$178.00
Crown-resin with high noble metal	$417.00
Crown-resin with noble metal	$365.00
Crown-porcelain/ceramic substrate	$490.00
Crown-porcelain fused high noble metal	$432.00
Crown-porcelain fused predominantly base metal	$432.00
Crown-porcelain fused to noble metal	$432.00
Crown-full cast high noble metal	$432.00
Crown-full cast predominantly base metal	$432.00
Crown-full cast noble metal	$432.00
Crown-3/4 cast metallic	$473.00

Other Prosthodontic Services

Cast post and core	$146.00
Prefabricated post and core	$121.00
Temporary crown (fractured tooth)	$76.00
Recement inlay	$42.00
Recement crown	$44.00
Implants	By Report

Complete Dentures (including routine postdelivery care)

Complete Maxillary	$577.00
Complete Mandibular	$577.00
Immediate Maxillary	$585.00
Immediate Mandibular	$540.00

Partial Dentures (including routine postdelivery care)

Maxillary Partial Denture	$430.00
Mandibular Partial Denture	$430.00

Adjustments to Dentures

Adjust complete denture-Maxillary	$31.00
Adjust complete denture-Mandibular	$31.00
Adjust partial denture-Maxillary	$31.00
Adjust partial denture-Mandibular	$31.00

Repairs to Complete Dentures

Repair broken complete denture base	$70.00
Replace missing or broken teeth (each tooth)	$57.00

Repairs to Partial Dentures

Repair resin denture base	$71.00
Repair cast framework	$65.00
Repair or replace broken clasp	$77.00
Replace broken teeth-per tooth	$64.00
Add tooth to existing partial denture	$75.00
Add clasp to existing partial denture	$75.00

Denture Rebase Procedures

Rebase complete denture-Maxillary	$127.00
Rebase complete denture-Mandibular	$127.00
Rebase partial denture-Maxillary	$142.00
Rebase partial denture-Mandibular	$142.00

Denture Reline Procedures

Reline complete denture (chairside)-Maxillary	$103.00
Reline complete denture (chairside)-Mandibular	$103.00
Reline partial denture (chairside)-Maxillary	$92.00
Reline partial denture (chairside)-Mandibular	$92.00
Reline complete denture (laboratory)-Maxillary	$176.00
Reline complete denture (laboratory)-Mandibular	$176.00
Reline partial denture (laboratory)-Maxillary	$176.00
Reline partial denture (laboratory)-Mandibular	$176.00

Other Removable Prosthetic Services

Interim partial denture-Maxillary	$201.00
Interim partial denture-Mandibular	$201.00

Bridge Pontics

Pontic-cast high noble metal	$432.00
Pontic-cast predominantly base metal	$412.00
Pontic-cast noble metal	$432.00
Pontic-porcelain fused to high noble metal	$432.00
Pontic-porcelain fused to predominantly base metal	$432.00
Pontic-porcelain fused to noble metal	$432.00
Pontic-resin with high noble metal	$432.00
Pontic-resin with predominantly base metal	$432.00
Pontic-resin with noble metal	$432.00

Retainers

Cast metal retainer for resin bonded fixed prosthesis.....$207.00

Bridge Retainers-Crowns

Abutment crown-resin with high noble metal $432.00
Abutment crown-resin with noble metal.....$432.00
Abutment crown-porcelain fused to high noble metal.....$432.00
Abutment crown-porcelain fused to predominantly base metal $432.00
Abutment crown-porcelain fused to noble metal.....$432.00
Abutment crown-3/4 cast high noble metal $420.00
Abutment crown-full cast high noble metal.....$432.00
Abutment crown-full cast predominantly base metal $432.00
Abutment crown-full cast noble metal.....$432.00

Other Fixed Prosthetic Services

Recement fixed partial denture $56.00

ORAL SURGERY

Oral surgery if performed by your Dentist when you require an extraction or other oral surgery.

Extractions (includes local anesthesia and routine postoperative care)

Single tooth $60.00
Each additional tooth $57.00
Root removal-exposed roots $73.00

Surgical Extractions (includes local anesthesia and routine postoperative care)

Surgical removal of erupted tooth.....$113.00
Removal of impacted tooth-soft tissue $136.00
Removal of impacted tooth-partially bony $176.00
Removal of impacted tooth-completely bony.....$200.00
Removal of impacted tooth-completely bony, with complications $223.00
Root recovery (surgical removal of residual tooth roots).....$115.00

Other Surgical Procedures

Biopsy of oral tissue-hard $113.00
Biopsy of oral tissue-soft $124.00
Incision/drain of abscess-intraoral soft tissue.. ..... $71.00

Repair of Traumatic Wounds

Suture of recent small wounds up to 5 cm $36.00

ANESTHESIA

Your Dentist may recommend that you be given an anesthetic before the necessary dental procedures are performed. You may only need a local anesthetic which is applied directly to the area your Dentist will be working on. If I.V. anesthesia, general anesthesia, intra muscular anesthesia or premedication is needed, these charges will be your responsibility at the Dentist's customary and reasonable fee.

Anesthesia

Local anesthesia $14.00
General anesthesia-first 30 minutes $150.00*
General anesthesia-each additional 15 minutes $53.00*
*General anesthesia is covered under this dental contract if the member's medical contract does not cover.

MISCELLANEOUS SERVICES

Behavior Management $25.00
Office visit-after hours $56.00
Emergency palliative treatment.... ..... $52.00

SAMPLE OF REDUCED FEE SERVICES BY PARTICIPATING SPECIALTY OFFICE

These co-payments apply to services rendered by a Participating Specialty Office only. Services provided by a Participating Dental Office are covered on a separate list in this booklet.

Clinical Oral Examinations

Periodic oral examination $30.00
Limited oral exam-problem focused $50.00

X-Rays

Intraoral-complete series $72.00
Intraoral-periapical-first film $20.00
Intraoral-periapical-each additional film $12.00
Intraoral-occlusal film $22.00
Bitewing-single film $18.00
Bitewings-two films $29.00
Bitewings-four films $37.00
Panoramic film $59.00

Tests and Consultations

Pulp vitality tests $31.00
Consultation-per session $46.00

PREVENTIVE

These services are performed by your Dentist or a licensed dental hygienist to help prevent certain conditions from occurring.

Dental Prophylaxis

Prophylaxis-adult $50.00
Prophylaxis-child $44.00

Topical Fluoride Treatment

Topical application of fluoride (including prophylaxis)-child $49.00
Topical application of fluoride (excluding prophylaxis)-child $24.00

Other Preventive Services

Dietary planning for the control of dental caries $24.00
Oral hygiene instruction $32.00
Sealant-per tooth $33.00

RESTORATIVE

These services are performed by your Dentist to restore tooth structure lost as a result of dental decay.

Amalgam Restorations (including polishing)

One surface, primary $59.00
Two surfaces, primary $68.00
Three surfaces, primary $76.00
One surface, permanent $72.00
Two surfaces, permanent $86.00
Three surfaces, permanent $101.00
Four or more surfaces, permanent $115.00

Resin or Composite Restorations

Resin one surface, anterior-permanent $93.00
Resin two surfaces, anterior-permanent $118.00
Resin three surfaces, anterior-permanent $137.00
Resin one surface, posterior-permanent $97.00
Resin two surfaces, posterior-permanent $131.00
Resin three surfaces, posterior-permanent $163.00
Labial veneer (laminate)-chairside $313.00

Other Restorative Services

Prefabricated stainless steel crown-primary tooth $136.00
Prefabricated stainless steel crown-permanent tooth $149.00
Prefabricated resin crown $158.00
Sedative filling $60.00
Crown build-up, including any pins $136.00
Pin retention-per tooth, in addition to restoration $50.00

ENDODONTICS

These services are performed by your Dentist to treat diseases of the tooth pulp nerve and their associated structures.

Pulp Capping

Pulp cap-direct $47.00
Pulp cap-indirect $63.00

Pulpotomy

Therapeutic pulpotomy $85.00

Root Canal Therapy (including treatment plan, clinical procedures, and follow-up care)

Anterior (excluding final restoration) $404.00
Bicuspid (excluding final restoration) $460.00
Molar (excluding final restoration) $566.00

Periapical Services

Apicoectomy/periradicular surgery-anterior $471.00
Apicoectomy/periradicular surgery-bicuspid $527.00
Retrograde filling-per root $113.00

PERIODONTICS

These services are performed by our Dentist or a licensed dental hygienist to treat diseases of the gums and supporting structures.

Surgical Services (including usual postoperative services)

Gingivectomy or gingivoplasty-per quadrant $380.00
Gingivectomy or gingivoplasty-per tooth $114.00
Gingival curettage-per quadrant $143.00
Osseous surgery-per quadrant $735.00

Adjunctive Periodontal Services

Perio scaling and root planing-per quadrant $135.00

PROSTHODONTICS

These services are performed by your Dentist to repair tooth structure lost as a result of dental decay or replace missing teeth with full or partial dentures, crowns and bridges.

Space Maintenance (passive appliances)

Space maintainer-fixed-unilateral $205.00
Space maintainer-fixed-bilateral $301.00
Space maintainer-removable-unilateral $205.00
Space maintainer-removable-bilateral $337.00
Recement of space maintainer $39.00

Inlay Restorations

Inlay-metallic-two surfaces	$437.00
Inlay-metallic-three surfaces	$467.00

Crowns-Single Restoration Only

Crown-resin with high noble metal	$509.00
Crown-resin with predominantly base metal	$403.00
Crown-resin with noble metal	$372.00
Crown-porcelain/ceramic substrate	$565.00
Crown-porcelain fused high noble metal	$486.00
Crown-porcelain fused predominantly base metal	$486.00
Crown-porcelain fused to noble metal	$486.00
Crown-full cast high noble metal	$486.00
Crown-full cast predominantly base metal	$486.00
Crown-full cast noble metal	$486.00
Crown-3/4 cast metallic	$535.00

Other Prosthodontic Services

Cast post and core	$209.00
Prefabricated post and core	$164.00
Temporary crown (fractured tooth)	$138.00
Recement inlay	$56.00
Recement crown	$60.00
Implants	By Report

Complete Dentures (including routine postdelivery care)

Complete Maxillary	$721.00
Complete Mandibular	$721.00
Immediate Maxillary	$749.00
Immediate Mandibular	$708.00

Partial Dentures (including routine postdelivery care)

Maxillary Partial Denture	$766.00
Mandibular Partial Denture	$766.00

Adjustments to Dentures

Adjust complete denture-Maxillary	$50.00
Adjust complete denture-Mandibular	$50.00
Adjust partial denture-Maxillary	$50.00
Adjust partial denture-Mandibular	$50.00

Repairs to Complete Dentures

Repair broken complete denture base	$104.00
Replace missing or broken teeth (per tooth)	$83.00

Repairs to Partial Dentures

Repair resin denture base	$104.00
Repair cast framework	$101.00
Repair or replace broken clasp	$123.00
Replace broken teeth (per tooth)	$95.00
Add tooth to existing partial denture	$111.00
Add clasp to existing partial denture	$122.00

Denture Rebase Procedures

Rebase complete denture-Maxillary	$241.00
Rebase complete denture-Mandibular	$241.00
Rebase partial denture-Maxillary	$252.00
Rebase partial denture-Mandibular	$252.00

Denture Reline Procedures

Reline complete denture (chairside)-Maxillary	$182.00
Reline complete denture (chairside)-Mandibular	$182.00
Reline partial denture (chairside)-Maxillary	$160.00
Reline partial denture (chairside)-Mandibular	$160.00
Reline complete denture (laboratory)-Maxillary	$227.00
Reline complete denture (laboratory)-Mandibular	$227.00
Reline partial denture (laboratory)-Maxillary	$227.00
Reline partial denture (laboratory)-Mandibular	$227.00

Other Removable Prosthetic Services

Interim partial denture-Maxillary	$295.00
Interim partial denture-Mandibular	$295.00

Bridge Pontics

Pontic-cast high noble metal	$486.00
Pontic-cast predominantly base metal	$458.00
Pontic-cast noble metal	$486.00
Pontic-porcelain fused to high noble metal	$486.00
Pontic-porcelain fused to predominantly base metal	$486.00
Pontic-porcelain fused to noble metal	$486.00
Pontic-resin with high noble metal	$486.00
Pontic-resin with predominantly base metal	$486.00
Pontic-resin with noble metal	$486.00

Retainers

Cast metal retainer for resin bonded fixed prosthesis	$300.00

Bridge Retainers-Crowns

Abutment crown-resin with high noble metal	$486.00
Abutment crown-resin with noble metal	$486.00
Abutment crown-porcelain fused to high noble metal	$486.00
Abutment crown-porcelain fused to predominantly base metal	$486.00
Abutment crown-porcelain fused to noble metal	$486.00
Abutment crown-3/4 cast high noble metal	$486.00
Abutment crown-full cast high noble metal	$486.00
Abutment crown-full cast predominantly base metal	$486.00
Abutment crown-full cast noble metal	$486.00

Other Fixed Prosthetic Services

Recement fixed partial denture	$84.00

ORAL SURGERY

Oral surgery is performed by your Dentist when you require an extraction or other oral surgery.

Extractions (includes local anesthesia and routine postoperative care)

Single tooth	$79.00
Each additional tooth	$72.00
Root removal-exposed roots	$110.00

Surgical Extractions (includes local anesthesia and routine postoperative care)

Surgical removal of erupted tooth	$144.00
Removal of impacted tooth-soft tissue	$161.00
Removal of impacted tooth-partially bony	$197.00
Removal of impacted tooth-completely bony	$231.00
Removal of impacted tooth-completely bony, with complications	$255.00
Root recovery (surgical removal of residual tooth roots)	$155.00

Other Surgical Procedures

Biopsy of oral tissue-hard	$199.00
Biopsy of oral tissue-soft	$176.00
Incision/drain of abscess-intraoral soft tissue	$115.00

Repair of Traumatic Wounds

Suture of recent small wounds up to 5cm	$65.00

ANESTHESIA

Your Dentist may recommend that you be given an anesthetic before the necessary dental procedures are performed. You may only need a local anesthetic which is applied directly to the area your Dentist may be working on.

Anesthesia

Local anesthesia $14.00
General anesthesia-first 30 minutes $150.00*
General anesthesia-each additional 15 minutes $53.00*

*General anesthesia is covered under this dental contract if the member's medical contract does not cover.

MISCELLANEOUS SERVICES

Behavior Management $25.00
Office visit-after hours $56.00
Emergency palliative treatment $52.00

IMPORTANT: YOUR PARTICIPATING DENTAL OFFICE WILL CHARGE YOU A $20 CHARGE IF YOU FAIL TO CANCEL AN APPOINTMENT OR GIVE LESS THAN 24 HOURS NOTICE THAT YOU DO NOT INTEND TO KEEP A SCHEDULED APPOINTMENT. THIS CHARGE IS **NOT** REIMBURSABLE BY ANTHEM BLUE CROSS.

PART VII ORTHODONTIC SERVICES AT A REDUCED FEE

Your Anthem Blue Cross Dental SelectHMO Plan provides the orthodontic services at a reduced fee, as described below. Please read the following information so that you may know how to take advantage of these services. These services are subject to all the terms, conditions, limitations and exclusions of this Anthem Blue Cross Dental SelectHMO Agreement.

Orthodontic services are provided to prevent or correct the abnormal positioning or misalignment of teeth (malocclusion).

ORTHODONTIC TREATMENT MUST BE PROVIDED BY A PARTICIPATING ORTHODONTIST CONTRACTING WITH ANTHEM BLUE CROSS TO PROVIDE ORTHODONTIC SERVICES FOR YOU AND YOUR FAMILY MEMBERS.

A. HOW TO OBTAIN CARE

If you or a Family Member require the services of an orthodontist, refer to the directory to select a Participating Orthodontist or call the Anthem Blue Cross Dental Customer Service department at (888) 209-7852.

Contact the orthodontist most convenient to your location to schedule an appointment. ONLY THE ORTHODONTISTS IN THIS DIRECTORY ARE AUTHORIZED TO PROVIDE ORTHODONTIC SERVICES FOR YOU AND YOUR FAMILY MEMBERS.

When you come in for your appointment, you will be required to show your Anthem Blue Cross Dental SelectHMO identification card.

If you need to cancel or reschedule an appointment, please notify the orthodontist as far in advance as possible. YOUR PARTICIPATING ORTHODONTIC OFFICE WILL CHARGE YOU A $20 CHARGE IF YOU FAIL TO CANCEL AN APPOINTMENT OR GIVE LESS THAN 24 HOURS NOTICE THAT YOU DO NOT INTEND TO KEEP A SCHEDULED APPOINTMENT. THIS CHARGE IS **NOT** REIMBURSABLE BY ANTHEM BLUE CROSS.

B. WHAT'S SERVICES ARE AVAILABLE

Orthodontic services include the following when provided by a Participating Orthodontist:

Orthodontic Consultation: Initial consultation to determine the extent of required orthodontic services.

Full Treatment: For children, adolescents and adults for correction of malocclusions.

Interceptive/Corrective (aka Retention) Treatment: Headgear, functional appliances, minor tooth movement and molar uprighting to correct malocclusions.

C. YOUR CO-PAYMENTS

Your Co-Payments are listed as follows:

Adults age 18 and over $3,045.00
Children through age 17 .....$2,870.00
Retention.....$210.00

The patient charge for orthodontics is determined from the SCHEDULE OF CO-PAYMENTS. Any down payments and amounts to be paid monthly by the Member based on this charge will be decided between the orthodontist and the Member.

D. LIMITATIONS AND EXCLUSIONS

In addition to the items listed in the sections of your Agreement entitled EXCLUSIONS AND LIMITATIONS, orthodontic services are subject to the following limitations and exclusions:

1. Orthodontic Limitations

a. **Authorized Orthodontic Services -** Orthodontic services must be received from a Participating Orthodontic Office.

b. **Loss of Coverage During Orthodontic Treatment -** In the event of a Member's loss of coverage, for any reason, and at the time of loss of coverage, the Member is still receiving orthodontic treatment the Member will be responsible for the remainder of the cost for that treatment, at the Participating Orthodontist's usual and customary fee, prorated for the number of months of treatment remaining.

2. Orthodontic Exclusions (when the reduced fee does not apply)

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

b. **Replacement of Orthodontic Appliances -** Replacement of lost or stolen orthodontic appliances or repair of orthodontic appliances broken due to negligence of the Member.

c. **Surgical Procedures Incidental to Orthodontic Treatment** - Surgical procedures incidental to orthodontic treatment, including, but not limited to extraction of teeth, solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate.

d. **Orthodontic Services Provided Before or After The Term of Member's Coverage** – Treatment of orthodontic cases begun prior to the Member's Effective date of eligibility or after the termination of eligibility for coverage.

e. **Changes in Treatment** – Changes in treatment necessitated by an accident of any kind.

f. **T.M.J. or Hormonal Imbalance Orthodontic Services** – Treatment related to the joint of the jaw (temporomandibular joint, TMJ) and/or hormonal imbalance.

PART VIII NON-DUPLICATION OF ANTHEM BLUE CROSS BENEFITS

If, while covered under this Individual Agreement, you are also covered by another Anthem Blue Cross Individual dental Agreement:

1. You will be entitled only to the benefits of the dental agreement with the greater benefits, and

2. We will refund any subscription charges received under the dental agreement with the lesser benefits, covering the time period both agreements were in effect. However, any claims payments made by us under the dental agreement with the lesser benefits will be deducted from any such refund of subscription charges.

PART IX EXCLUSIONS AND LIMITATIONS

No benefits are provided for or in connection with the following:

A. **ANY SERVICES NOT PERFORMED BY YOUR ANTHEM BLUE CROSS DENTAL SELECTHMO PARTICIPATING DENTAL OFFICE, PARTICIPATING SPECIALTY OFFICE OR PARTICIPATING ORTHODONTIC OFFICE.**

B. **Workers' Compensation:** Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication, settlement or otherwise under any worker's compensation or occupational disease law, even in you do not claim these benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to worker's compensation, Anthem Blue Cross will provide the benefits of this Plan for such conditions subject to its right of recovery and reimbursement under California Labor Code Section 4903.

C. **Nuclear Energy:** Conditions caused by the inadvertent release of nuclear energy when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

D. **Government Services:** Any services provided by a local, state or federal government agency except when payment under this Plan expressly required by federal or state law.

E. **Fractures or Dislocations:** Treatment of fractures or dislocations.

F. **Hospital Charges:** Hospital and associated Physician charges of any kind or charges for any dental treatment which cannot be performed in the Participating Dental Office.

G. **Services Provided Before The Term of The Member's Coverage:** Dental treatment or expenses incurred or in connection with any dental procedure started prior to the Member's Effective Date.

H. **Treatment by a Non-Participating Dentist:** Any treatment to correct a dental condition that resulted from dental services performed by an Non-Participating Dentist while this coverage is in effect, and any dental services started by a Non-Participating Dentist will not be the responsibility of the Participating Dental Office or Anthem Blue Cross for completion.

I. **Cysts and Neoplasms:** Histopathological exams, and/or the removal of tumors, cysts, neoplasms, and foreign bodies not covered under the medical plan.

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

K. **Not Dentally Necessary:** A dental treatment plan which in the opinion of the Participating Dentist and/or Anthem Blue Cross is not Dentally Necessary for dental health or will not produce beneficial results.

L. **Questionable, Guarded or Poor Prognosis:** Teeth with questionable, guarded or poor prognosis are not covered for endodontic treatment, periodontal surgery or crown and bridge. Plan will allow for observation or extraction and prosthetic replacement.

M. **Drugs or Dispensing of Drugs:** Plan does not cover prescription drugs as a dental benefit.

N. **Primary Restorations:** Gold, porcelain or resin fillings on primary teeth are excluded.

O. **Services Received After the Benefit Limit Under This Agreement is Reached.**

P. **Non-Duplication of Medicare:** Any services to the extent that you are entitled to receive Medicare benefits for those services, whether or not Medicare benefits are actually paid. Any services for which payment may be obtained from any local, state or federal government agency (except Medi-Cal). If you are eligible for Part B of Medicare and do not enroll in it, we will still reduce the benefits payable under this Evidence of Coverage as if you were enrolled in Part B, and Medicare Part B benefits were paid. It is, therefore, important that you enroll in Part B of Medicare if you are eligible. Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.

PART X THIRD-PARTY LIABILITY

Under some circumstances, a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation on the part of such third party for an injury, disease or other condition for which a Member receives Covered Services. In that event, any benefits we pay under this Evidence of Coverage for such Covered Services will be subject to the following:

A. We will automatically have a lien, upon any amount you receive from the third party of the third party's insurer or guarantor by judgment, award, settlement or otherwise. Our lien will be in the amount of the benefits we pay under this Evidence of Coverage for treatment of the illness, disease, injury or condition for which the third party is liable.

B. You agree to advise us in writing of you claim against a third party within sixty (60) days of making such claim, and that you will take such action, furnish such information and assistance, and execute such papers as we may require to facilitate enforcement of our lien rights. You agree not to take any action that may prejudice our rights or interests under this Agreement. You agree also that failing to give us such notice, or failing to cooperate with us, or taking action that prejudices our rights will be a material breach of this Agreement. In the event of such material breach, you will be personally responsible and liable for reimbursing to us the amount of benefits we paid.

C. We will be entitled to collect on our lien even if the amount recovered by or for the Member (or his or her estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss suffered by the Member.

PART XI GENERAL PROVISIONS

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

B. **PROVIDING OF CARE:** We are not responsible for providing any type of hospital, medical, dental or similar care. Also, we are not responsible for the quality of any type of hospital, medical, dental or similar care received.

C. **BENEFITS NOT TRANSFERABLE:** You and your eligible Family Members are the only persons entitled to receive benefits under this Agreement. The right to benefits cannot be transferred.

D. **RELATIONSHIP OF PARTIES:** The Participating Dental Offices furnishing care or other benefits to a Subscriber or eligible Family Member do so as independent contractors with Anthem Blue Cross, and Anthem Blue Cross shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with any injuries suffered by a Subscriber or eligible Family Member while receiving care from the Participating Dental Offices.

E. **FORM OR CONTENT OF AGREEMENT:** No agent of Anthem Blue Cross may change this Agreement or waive any of its contents. Anthem Blue Cross may change the provisions of this Agreement at any time by mutual consent. No change in this Agreement is valid unless made by an endorsement signed by the officers of Anthem Blue Cross.

F. **INDIVIDUAL MEMBER CANCELLATION:** Anthem Blue Cross reserves the right to deny benefits to Members covered under this Agreement. Anthem Blue Cross will request and expect cancellation of Anthem Blue Cross Dental SelectHMO benefits of individual Members if you:

- Fail or refuse to make Co-Payments at the time services are rendered, or
- Interfere with the normal operations of the Dental Office, or
- Use threatening or aggressive language, or
- Refuse to follow a prescribed course of treatment and the Dentist believes that no professionally acceptable alternative exists, the Member will be advised. If the Member continues to refuse to follow the prescribed course of treatment, that Member’s coverage will be cancelled.

G. **NOTICE (Mailing Addresses):** Any notice required of Anthem Blue Cross in this Agreement will be mailed to the address listed on our records. You will meet any notice requirement by mailing the notice to:

Anthem Blue Cross Dental SelectHMO
Anthem Blue Cross
P.O. Box 6666
Oxnard, CA 93031-6666

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

I. **TERMS OF COVERAGE:**

1. In order for you to be entitled to benefits under this Agreement, your coverage under this Agreement must be in effect on the date expense giving rise to a claim for benefits is incurred. Under this Agreement, an expense is incurred on the date the Subscriber or Family Member receives a service or supply for which the charge is made.

1. This Agreement, including all terms, benefits, conditions, limitations and exclusions may be changed by us as provided in Section C of Part III, TERM OF YOUR AGREEMENT.

2. The Benefit to which you may be entitled will depend on the terms of coverage as set out in the Agreement in effect on the date the expense giving rise to a claim for benefits is incurred.

J. **DENTAL RECORDS:** Anthem Blue Cross reserves the right to examine dental records such as X-rays, study models and if needed, an examination of the patient in connection with the processing of a claim.

K. **INDEPENDENT CONTRACTORS:** The relationship between Anthem Blue Cross and the Participating Dental Office is that of an independent contractor. Dentists and other dental health professionals within the Dental Office are not agents or employees of Anthem Blue Cross, nor is Anthem Blue Cross or any employee of Anthem Blue Cross, an employee or agent of any Dental Office.

L. **MEDICAL/DENTAL NECESSITY:** The benefits of this Agreement are provided only for services that are Dentally Necessary for dental health as determined by Anthem Blue Cross. The services must be prescribed by the Participating Dentist for the direct care and treatment of a covered dental service. They must be standard dental procedures, recognized by the American Dental Association, received for the dental condition being treated and must be legal in the United States.

M. **FINANCIAL RESPONSIBILITY:** In the event you transfer or terminate enrollment from your Participating Dental Office, any costs to transfer or duplicate the dental records and/or X-rays to the new office will be your financial responsibility and subject to the customary and reasonable fees of the Participating Dental Office, not to exceed $25.00.

If you reside or relocate outside of the Anthem Blue Cross Dental SelectHMO Service area, and decide to have care provided or treatment completed by a dental office other than your Participating Dental Office, you and NOT Anthem Blue Cross will be financially responsible.

N. **CONFORMITY WITH THE LAW:** Any provisions of this Agreement which, on its effective date, is in conflict with any applicable statute, regulation or other law is hereby amended to conform with the minimum requirements of such law.

O. Anthem Blue Cross shall neither increase the subscription charges payable by you, nor decrease in any manner the benefits and coverages provided hereunder, except after at least thirty (30) days' prior written notice to you.

P. Anthem Blue Cross shall provide written notice to you within a reasonable period of time of any Participating Provider's termination or breach of, or inability to perform under, any provider contract, if Anthem Blue Cross determines that you my be materially and adversely affected thereby.

Q. Upon the termination of the contract or other agreement with any Participating Provider, Anthem Blue Cross shall be liable to pay the cost of Covered Services (other than applicable Co-Payments) rendered by that provider to a Member who retains eligibility under this Agreement or by operation of law, and who is under the care of that provider at the time of such termination, and that provider shall continue to provide such services to the Member in accordance with the terms of this Agreement, until the services being rendered are completed, unless reasonable and dentally appropriate provision is made for the assumption of such services by another provider.

R. Anthem Blue Cross is subject to the requirements of the Knox-Keene Health Care Service Act of 1975, as amended, as set forth at Chapter 2.2 of Division 2 of the California Health and Safety Code and at Subchapter 5.5 of Chapter 3 of Title 10 of the California Code of Regulations, and any provision required to be stated herein by either of the above shall bind Anthem Blue Cross whether or not provided in this Agreement. This Agreement shall be construed and enforced in accordance with the laws of the State of California.

S. In accordance with California law, Members will not be required to pay any Participating Provider or other dental care provider for amount owed to that provider by Anthem Blue Cross (not including Co-Payments and Deductibles), even in the unlikely event that Anthem Blue Cross fails to pay the provider. Members may be liable, however, to pay Non-Participating Providers for any amounts not paid to them by Anthem Blue Cross.

T. **PROVIDER REIMBURSEMENT.** Participating dental offices are generally paid a capitation fee, a set and agreed to dollar amount per member each month, for dental services. The Dentists also receive compensation from Plan Members who pay a defined co-payment for specific dental services. Participating dental offices may also receive additional reimbursement for certain types of specialty care or for overall efficiency. The terms of these arrangements vary by dental office. For additional information, you may contact us at the telephone number on your identification card or by contacting your dental office.

U. **CONTINUITY OF CARE**. If we terminate our contractual relationship with a participating provider and you are undergoing a course of treatment from that provider at the time the contract is terminated, you may be able to continue to receive services from that provider (but only if such provider agrees to continue to comply with the same contractual requirements that applied prior to termination). To qualify, you must have an acute or serious chronic condition. You may request this continuity of care by calling us at the customer service telephone number listed on your ID card. If approved, services may be received for a limited period of time, but no longer than 90 days, unless you cannot be safely transferred to a participating provider. Coverage is provided according to the terms and conditions of this plan applicable to participating providers.

PUBLIC POLICY PARTICIPATION

We have established a public policy committee (that we call our Consumer Relations Committee) to advise our Board of Directors. This Committee advises the Board about how to assure the comfort, dignity, and convenience of the people we cover. The Committee consists of members covered by our health plan, participating providers and a member of our Board of Directors. The Committee may review our financial information and information about the nature, volume, and resolution of the complaints we receive. The Consumer Relations Committee reports directly to our Board.

PART XII GRIEVANCE PROCEDURES

If you are dissatisfied or have a grievance regarding services from your Participating Dental Office, Participating Orthodontic Office or Participating Specialty Office under this Anthem Blue Cross Dental SelectHMO Agreement, contact your Participating Dental Office, Participating Orthodontic Office or Participating Specialty Office. If you are unable to resolve your concerns with the Participating Dental Office or Participating Specialty Office, you should submit a formal complaint in writing to Anthem Blue Cross. You must include all pertinent information from your Anthem Blue Cross Dental SelectHMO identification card and the details and circumstances of your concern or problem.

Anthem Blue Cross will request all pertinent information regarding your concerns from all the parties involved. Upon receipt of all requested information, Anthem Blue Cross will review and if possible, resolve the matter. Anthem Blue Cross should be allowed thirty (30) working days after receipt of the formal complaint and applicable documentation to reach a resolution.

If your concern or problem with the services provided by your Participating Dental Office, Participating Orthodontic Office or Participating Specialty Office cannot be resolved by Anthem Blue Cross, Anthem Blue Cross may recommend that the complaint be submitted for impartial review to the California Dental Association's Peer Review process or to another qualified mediator for impartial review and settlement.

If you are dissatisfied or have a concern with Anthem Blue Cross, contact the Dental Customer Service department indicated on your identification card. If they are unable to resolve your concerns, you should submit a formal complaint in writing requesting review by the Grievance Committee. This committee is comprised of one representative from each of the following: The Anthem Blue Cross Dental SelectHMO Dental Director, Plan Administrator, Professional Relations staff representative, a Quality Assurance staff member and two grievance coordinators.

If you are dissatisfied with the resolution of your grievance, or if your grievance has not been resolved, you may submit your grievance to the California Department of Corporations for review prior to binding arbitration. (see DEPARTMENT OF CORPORATIONS). If your case involves an imminent threat to you health, you are not required to complete our grievance process, but may immediately submit your grievance to the Department of Corporations for review.

If at the conclusion of review of your grievance by the Department of Corporations, you continue to be dissatisfied with its resolution, your remedy is binding arbitration (see BINDING ARBITRATION).

DEPARTMENT OF CORPORATIONS

The California Department of Corporations is responsible for regulating health care service plans. The department's Health Plan Division has a toll-free telephone number **1 888-466-2219** to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers **(1-877-688-9891 (TDD))** to contact the department. The department's Internet website **(http://www.hmohelp.ca.gov)** has complaint forms and instructions online.

If you have a grievance against your health plan, you should first telephone your plan at **(888) 209-7852** and use the plan's grievance process before contacting the Health Plan Division. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 60 days, you may call the Health Plan Division for assistance. The plan's grievance process and the Health Plan Division's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

PART XIII BINDING ARBITRATION

A. Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Agreement or breach 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.

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

C. The arbitration is begun by the Member making written demand on Anthem Blue Cross. The arbitration will be conducted by the American Arbitration Association according to its commercial rules of arbitration. The arbitration shall be held in the State of California.

D. Anthem Blue Cross and the Member will each be responsible for paying their own shares of the fees and expenses of the arbitration; however, we may pay the Member's share of these fees in cases of extreme hardship, as determined by the American Arbitration Association. An application to claim extreme hardship under this section may be obtained from the American Arbitration Association.

E. The Member and Anthem Blue Cross agree to be bound by the arbitration provision and acknowledge that they are giving up their right to a trial by court or jury.

F. The arbitration findings will be final and binding except to the extent that California or Federal law provide for the judicial review of arbitration proceeding.

Please send all Binding Arbitration demands in writing to the address indicated on your ID Card.

COMPLAINTS

If you have a complaint about services from Anthem Blue Cross, please call Anthem Blue Cross first. The telephone number is listed on your Identification Card or you may write to Anthem Blue Cross, at the P.O. Box indicated on your Identification Card, marked to the attention of the Dedicated Service Unit also named on your Identification Card.

PART XIV QUARTERLY SUBSCRIPTION CHARGES

SINGLE	TWO PARTY	FAMILY
$39.00	$78.00	$117.00

The preceding subscription charges are payable quarterly in advance and due the first of the month.

We reserve the right to change the subscription charges on thirty days written notice to the Subscriber prior to the close of any billing term. The change will become effective on the date shown in the notice, and payment of the new charges will indicate acceptance of the change.