Anthem BlueCross

Anthem Family Dental PPO
For Individuals and Families

Good health starts with a healthy mouth.[1]
Good dental health and routine visits to your dentist can pay off in a bigger way than just giving you a healthy smile. Conditions in the mouth can, and often do, affect the rest of the body. Dental exams can help recognize as many as 120 medical conditions, making them extremely important to your overall health.

This benefit summary outlines the basics of your **Anthem Blue Cross (Anthem) Family Dental PPO** plan, providing you with a quick reference of deductibles, coinsurance, limitations and exclusions when you receive covered services from a participating dental provider. Please refer to the plan certificate for a more complete explanation of specific services covered by the plan.

CHILDREN'S DENTAL PPO BENEFITS AT A GLANCE:

The following benefits are available to pediatric members through the end of the month after turning age 19. After you have met your annual deductible, Anthem will pay for dental services at the listed coinsurance amounts up to the "maximum allowed amount" as determined by Anthem for each covered service. However, there may be different levels of coinsurance, depending on whether you choose to receive services from a participating (in-network) or a nonparticipating (out-of-network) dentist.

Coverage Year	Calendar Year
Insured Age Limit	End of month in which insured turns age 19
Dental Specific Annual Deductible[2]	$65 per covered child / $130 per family (two+ children)
Waiting Periods	None

DENTAL SERVICES (examples of what is/is not covered by the plan):	IN-NETWORK Anthem pays:	OUT-OF-NETWORK Anthem pays:
Annual Benefit Maximum	No maximum	No maximum
Annual Out-of-Pocket Maximum	$350 / $700 per family[3]	Not applicable
Diagnostic & Preventive Services, for example: • Periodic oral exam • Teeth cleaning • Bitewing X-rays	100%	90%
Basic Services, for example: • Composite (tooth-colored) fillings on anterior (front) teeth • Amalgam (silver-colored) fillings or composite fillings on posterior (back) teeth • Periodontal maintenance	80%	70%
Endodontic Services, for example: • Root canal	50%	50%
Periodontal Services, for example: • Scaling and root planing	50%	50%
Oral Surgery Services	50%	50%
Major Services, for example: • Crowns	50%	50%
Prosthodontic Services, for example: • Dentures and bridges	50%	50%
Medically Necessary Orthodontic Services	50%	50%
Medically Necessary Orthodontic Lifetime Maximum	No maximum	No maximum

[1]According to research, signs and symptoms of as many as 120 medical conditions can be first detected by an examination of the mouth, throat and neck – and earlier detection means earlier treatment. (Source: Oral Diagnosis, Oral Medicine and Treatment Planning, 1994, S. Bricker, R. Langlais, C. Miller.)
[2]Applies to all services except Diagnostic & Preventive
[3]Family out-of-pocket maximum applies if there are two or more children per family only; there is no out-of-pocket maximum for children receiving out-of-network services.

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ADULT DENTAL PPO BENEFITS AT A GLANCE:

The following benefits are available to adult members age 19 and over. After you have met your deductible, Anthem will pay for dental services at the listed coinsurance amounts up to the "maximum allowed amount" payable for each covered dental procedure as determined by Anthem. However, there may be different levels of coinsurance, depending on whether you choose to receive services from a participating (in-network) or a nonparticipating (out-of-network) dentist.

Coverage Year	Calendar Year
Annual Deductible[1]	$50 per covered person
Waiting Periods	Six months for Major Services (waived with proof of prior coverage with Anthem or with another carrier)

DENTAL SERVICES (examples of what is/is not covered by the plan):	IN-NETWORK Anthem pays:	OUT-OF-NETWORK Anthem pays:
Annual Benefit Maximum	$1,500	
Annual Out-of-Pocket Maximum	Not applicable	Not applicable
Diagnostic & Preventive Services, for example: • Periodic oral exam • Teeth cleaning • Bitewing X-rays	100%	90%
Basic Services, for example: • Amalgam (silver colored) fillings • Anterior (front) composite (tooth colored) fillings • Posterior (back) composite fillings covered at amalgam allowance • Periodontal maintenance	80%	70%
Endodontic Services, for example: • Root canal	50%	50%
Periodontal Services, for example: • Scaling and root planing	50%	50%
Oral Surgery Services	50%	50%
Major Services, for example: • Crowns	50%	50%
Prosthodontic Services, for example: • Dentures and bridges	50%	50%
Medically Necessary Orthodontic Services	Not covered	Not covered
Medically Necessary Orthodontic Maximum	Not applicable	Not applicable

[1]Applies to all services except Diagnostic & Preventive; family deductible not applicable to adults

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of your certificate of coverage. In the event of a discrepancy between the information in this summary and the certificate of coverage, the certificate will prevail.

The in-network dental providers mentioned in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of Anthem Blue Cross.

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Choice of dentists

While your dental plan lets you choose any dentist, you may end up paying more for a service if you visit an out-of-network dentist. Why? Because in-network dentists have agreed to payment rates for various services and cannot charge you more. On the other hand, out-of-network dentists don't have a contract with us and are able to bill you for the difference between the total amount we allow to be paid for a service – the maximum allowed amount – and the amount they usually charge for a service. When they bill you for this difference, it is called "balance billing."

How Anthem dental decides on maximum allowed amounts

Anthem develops an out-of-network dental fee schedule/rate to determine the maximum allowed amount for services provided by an out-of-network dentist. This schedule may be changed or updated based on such things as reimbursement amounts accepted by dentists contracted with our dental plans, or other industry cost and usage data.

Here's an example of higher costs for out-of-network dental services

This is an example only. Your experience may be different, depending on your insurance plan, the services you receive and the dentist who provides the services.

Ted, a 28-year-old, gets a stainless steel crown from an out-of-network dentist, who charges $1,200 for the service and bills Anthem for that amount. Anthem's maximum allowed amount for this dental service is $800. That means there will be a $400 difference, which the dentist can "balance bill" Ted.

Since Ted will also need to pay $400 coinsurance, the total he'll pay the out-of-network dentist is $800. Here's the math:

- Dentist's charge: $1,200
- Anthem's maximum allowed amount: $800
- Anthem pays 50%: $400
- Ted pays 50% (coinsurance): $400
- Balance Ted owes the provider: $1,200 - $800 = $400
- Ted's total cost: $400 coinsurance + $400 provider balance = $800

In the example, if Ted had gone to an in-network dentist, his cost would be only $400 for the coinsurance because he would not have been "balance billed" the $400 difference.

Emergency dental treatment for the international traveler

As an Anthem dental member, you and your eligible, covered dependents automatically have access to the International Emergency Dental Program.* With this program, you may receive emergency dental care from our listing of credentialed dentists while traveling or working nearly anywhere in the world.

*The International Emergency Dental Program is managed by an independent company offering dental management services to Anthem. To learn more about the program, please visit the International Emergency Dental website at www.decaredental.com/internationalDentalProgram.do.

Finding a dentist is easy.

To select a dentist by name or location:

• Go to anthem.com/ca or the website listed on the back of your member ID card.

• Call the toll-free customer service number listed on the back of your member ID card.

TO CONTACT US:

Call	Write	E-mail
Call the toll-free number on the back of your member ID card to speak with a U.S.-based customer service representative during normal business hours. Calling after hours? We may still be able to assist you with our interactive voice-response system.	Look on the back of your member ID card for the address.	Go to anthem.com/ca or the website listed on the back of your member ID card.

Anthem does not discriminate based on race, color, ethnicity, national origin, religion, age, gender, gender identity, mental or physical disabilities, sexual orientation, genetic information, including pregnancy and expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health condition or health status in the administration of the plan (including enrollment, marketing practices, benefit designs, and benefit determinations).

Limitations & Exclusions (Children's Dental PPO Benefits)

Limitations – Below is a partial listing of dental plan limitations. Please see your certificate of coverage for a full list.

Diagnostic and Preventive Services
Periodic oral exam/evaluations Limited to one per six-month period
Teeth cleaning (prophylaxis) Limited to one per six-month period
Bitewing X-rays Limited to one series of films per six-month period
Complete series X-rays (panoramic or full-mouth) Limited to one series in any 36-month period
Sealants Limited to first and second molars
Fluoride treatment Limited to one per six-month period.

Basic Services
Fillings Replacement of a filling is covered only if it is defective, as evidenced by decay or fracture
Extractions Basic removal of teeth
Periodontal maintenance Limited to four per 12-month period

Major/Other Services
Crowns Limited to once per tooth in a 60-month period
Prefabricated stainless steel or ceramic crowns Limited to one per 12-month period
Fixed prosthodontics – bridges Covered once for members age 16 or older to replace missing permanent front teeth; we will cover up to five units of crown or bridgework per arch.
Removable prosthodontics – dentures and partials Replacement for partial dentures is not covered within 36 months of initial placement unless it is necessary due to natural tooth loss where addition or replacement of existing partial is not possible or the denture cannot be repaired
Root canal therapy, including culture canal and retreatment of previous root canal therapy Coverage is for permanent teeth only.

Periodontal scaling and root planing Limited to four treatments in any 12-month period for ages 13 and older
Surgical extractions Removal of impacted teeth is covered only when evidence of pathology exists.

Medically Necessary Orthodontic Services
Services for Medically Necessary Orthodontic Care will be subject to review. To be considered Medically Necessary Orthodontic Care, the service must meet criteria for medically necessary orthodontic care as established by the HLD Index. Consistent with current California Denti-Cal orthodontic criteria, we will cover orthodontic care when it is necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

Exclusions – Below is a partial listing of noncovered services. Please see your certificate of coverage for a full list.

Services provided before or after the term of this coverage Services received before your effective date or after coverage ends, unless otherwise specified in the dental plan certificate
Cosmetic orthodontic services Orthodontic braces, appliances and all related services that are not considered medically necessary
Cosmetic dentistry 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
Drugs and medications Intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care; analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care

Limitations & Exclusions (Adult Dental PPO Benefits)

Limitations – Below is a partial listing of dental plan limitations. Please see your Certificate of Coverage for a full list.

Diagnostic and Preventive Services
Oral evaluations (exams) Limited to two per 12-month period
Teeth cleaning (prophylaxis) Limited to two per 12-month period
Bitewing X-rays Limited to one series of films per 24-month period
Periapical X-rays Limited to four single X-rays per 12-month period
Occlusal X-rays Covered at two series per 24-month period
Complete series X-rays (panoramic or full-mouth) Limited to one series in any 60-month period

Basic Services
Fillings Replacement of a filling is covered only if it is defective, as evidenced by decay or fracture. Limited to one service per tooth surface per 24-month period
Basic extractions Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth; extraction of erupted tooth or exposed root
Brush biopsy Limited to one time per 36-month period per member age 20 to 39; covered one time per 12-month period per member age 40 and above

Major/Other Services
Crowns Limited to once per tooth in a seven-year period
Fixed prosthodontics – bridges Covered once per seven-year period
Removable prosthodontics – dentures and partials Covered once per seven-year period
Root canal therapy Limited to once per lifetime per tooth; coverage is for permanent teeth only.

Periodontal scaling and root planing Limited to once per quadrant in 36 months when the tooth pocket has a depth of four millimeters or greater
Periodontal surgery Limited to one complex service per single tooth or quadrant in any 36 months, and only if the pocket depth of the tooth is five millimeters or greater

Exclusions – Below is a partial listing of noncovered services. Please see your Certificate of Coverage for a full list.

Services provided before or after the term of this coverage Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate
Diagnostic & Preventive Services Sealants, topical fluoride applications, space maintainers
Orthodontic services Orthodontic braces, appliances and all related services
Cosmetic dentistry 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
Drugs and medications Intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care; analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.
Extractions Surgical removal of asymptomatic, nonpathologic third molars