



Prudent Buyer Choice Dental Plan A1X

We're Committed To Providing You With Great Dental Care Options

Dental care is an important part of your comprehensive health care coverage and well-being. Anthem Blue Cross knows being protected by dental insurance is an important safeguard for you and your family. We have been dedicated to providing you and your family with premier dental coverage for more than thirty years.

Diagnostic and preventive services are the key to maintaining good dental health. Dental coverage is designed to guarantee that you receive regular preventive care. With routine examinations, minor dental problems can be diagnosed and treated before major, more costly problems set in. Anthem Blue Cross' Choice Dental Plan can be instrumental in your long-term dental health.

How the Plan Works

You may choose between Dental Net, a dental HMO with an extensive network of quality dentists in California, or PPO Dental, one of the largest networks of participating dentists in the state. When you choose the PPO Dental Program, you also get the option of going out-of-network to any non-participating licensed dentist. However, the services you receive from out-of-network providers may not be covered at the participating provider benefit level. The dental plan you select applies to all enrolled family members.

During enrollment, you can enroll in the dental plan that fits your current needs and you may switch plans as often as every month. Simply call customer service at (800) 627-0004 by the fifteenth of the month and changes will be effective the first of the following month.

Your Choices

Dental Net is provided by Anthem Blue Cross offering a network of statewide dental offices. You select the office most convenient to your home or work.

Your selected dental office will coordinate all your dental services for you and your family members.

Dental Net includes:

- Statewide network of over 700 general dental offices and 990 specialty offices
- Most diagnostic and preventive care provided at no charge
- Low copayments for major services
- No claim forms; no deductibles; no Annual Benefit Maximum
- Orthodontic coverage included

PPO Dental Program is provided by Anthem Blue Cross Life and Health Insurance Company, and is a preferred provider dental insurance plan. The "participating dentists" have agreed to provide members with dental care at a negotiated fee, and take responsibility for obtaining any treatment authorizations required. You will be responsible for your annual deductible and for your portion of the cost of the covered services. Your dentist will submit claims for you.

Prudent Buyer Dental includes:

- Extensive statewide network with over 13,000 dentists
- Negotiated discounts on dental fees
- No claim forms
- Low out-of-pocket charges

Please note, if you choose a licensed dentist who does not participate in the PPO Dental Program network, your out-of-pocket expenses may be greater. You will be responsible for your annual deductible and for your portion of the Covered Expenses.

Please see your Evidence of Coverage (EOC) for details. You will also be asked to pay your portion of the bill at the time of service and submit claim forms for reimbursement.

PPO Late Entrant Waiting Period (Does not apply to Dental Net)

If you do not enroll in the Choice Dental Plan within 31 days of your eligibility date, you will be subject to a Late Entrant Waiting Period. This means that you will not be covered immediately for certain PPO dental program services.

Details of the Late Entrant Waiting Period can be found in the Exclusions and Limitations section of this document.

PPO Dental Deductible

A deductible is the amount of money you pay for a covered dental expense prior to benefits being paid under the plan. Only charges that are considered covered dental expenses will apply toward satisfaction of the deductible. Please refer to the deductible amount in the chart.

PPO Pre-Authorization

When the anticipated expense for any course of treatment exceeds \$350, we suggest that you pre-authorize the care. The authorization form, prepared by the attending dentist, needs to be submitted before treatment begins. If you use a PPO dentist, your dentist will submit this form for you. If you choose a dentist outside these networks it is your responsibility to ensure your dentist has pre-authorized your care with us.

Benefit Maximums (Does not apply to Dental Net)

Dental benefits are limited to a maximum payment for expenses incurred by each member during a calendar year. Please refer to the amount on the chart.

How Your Choices Work

Your choice of dental plans determines benefits and plan limitations. For example, the Dental Net plan has no deductibles or annual maximums. However, deductibles, annual maximums, and late entrant waiting periods for certain PPO dental program services will apply if you switch to the PPO Dental Program.

Even if you switch back and forth several times in a given year, the deductibles need to be met (only once) but the late entrant waiting periods will apply and the benefits can not exceed the annual maximum. These limitations have no impact on the Dental Net benefits, since there are no deductibles, late entrant waiting periods or maximums. You may not switch plans when you or a covered family member have work in progress. In order to switch options you must call or write our Customer Service department and make the option change. Charges for dental care from a non-approved option change will be your responsibility.

Your First Visit

Because preventive dental care is so important, your Choice Dental Plan provides benefits for X-rays and teeth cleaning regardless of which plan you choose. Soon after enrollment, you should call your participating dental office for an initial diagnostic examination. X-rays will usually be taken at this time to determine the overall condition of your teeth. Through routine check-ups, minor dental problems can often be diagnosed and treated before they become major problems. We encourage you to call your participating dental office whenever you need dental care.

Conditions of Service

Services must be provided by a licensed dentist and must be for treatment of dental disease, defect or injury, and are subject to any Exclusions and Limitations or Benefit Maximums specified under the plan.

Customer Service

A Customer Service representative is available to answer your questions and inquiries at (800) 627-0004.

Continuing Coverage

As required by federal law, certain restrictions and conditions apply to the right to continue coverage and are described in your Certificate or EOC.

	Dental Net Program	PPO Dental Program	
	Dental Net Dentists	PPO Dentists	Non-PPO Dentists
Calendar Year Deductible <i>(waived for Diagnostic & Preventive services provided by PPO dentists)</i>	N/A	\$50/member; maximum of \$150/family	
Annual Maximum	N/A	\$1,500	
Predetermination of Benefits	Applies only to specialty referrals	Charges in excess of \$350	
Covered Expense	Plan payments will be applied to the lesser of the charges billed by the provider or the following:		
Dental Net Dentists	Charges incurred for covered services received from or authorized by the member's participating dentist or participating dental group		
PPO Dentists	The Prudent Buyer Dental Plan negotiated rate or fee. <i>When using a participating dentist, insured persons are <u>not</u> responsible for the difference between the provider's usual charges and the negotiated amount.</i>		
Non-PPO Dentists	The amount calculated by us, as specified in the Certificate, for professional services in the dentist's geographical location. <i>When using a non-participating dentist, insured persons are responsible for the difference between the covered amount and actual charges, in addition to any deductible and copayment amounts.</i>		

Covered Services	Per Member Copay		
	Dental Net Program	PPO Dental Program ¹	
	Dental Net Dentists	PPO Dentists ²	Non-PPO Dentists ²
Diagnostic <i>(deductible waived for PPO services)</i>			
0120 – Periodic oral evaluation	No copay	No copay	20%
0140 – Limited oral evaluation – problem focused	No copay	No copay	20%
0150 – Comprehensive oral examinations	No copay	No copay	20%
0160 – Detailed and extensive oral evaluation	No copay	No copay	20%
0170 – Re-evaluation – Limited problem focused <i>(not post-operative visit)</i>	No copay	No copay	20%
0210 – X-rays – intraoral – complete series <i>(including bitewings)</i>	No copay	No copay	20%
0220 – X-rays – intraoral – periapical – first film	No copay	No copay	20%
0230 – X-rays – intraoral – periapical – each additional film	No copay	No copay	20%
0240 – X-rays – intraoral – occlusal film	No copay	No copay	20%
0270 – X-rays – bitewing – single film	No copay	No copay	20%
0272 – X-rays – bitewings – two films	No copay	No copay	20%
0274 – X-rays – bitewing – four films	No copay	No copay	20%
0277 – X-rays – vertical bitewings	No copay	No copay	20%
0330 – X-rays – panoramic film	No copay	No copay	20%
0460 – Pulp vitality tests	No copay	No copay	20%
0470 – Diagnostic casts	No copay	No copay	20%
9310 – Consultation – per session	No copay	No copay	20%
Preventive <i>(deductible waived for PPO services)</i>			
1110 – Prophylaxis – adult	No copay ³	No copay	20%
1120 – Prophylaxis – child	No copay ³	No copay	20%
1201 – Topical Fluoride – child <i>(including prophylaxis)</i>	No copay	No copay	20%
1203 – Topical Fluoride – child <i>(excluding prophylaxis)</i>	No copay	No copay	20%
1204 – Topical Fluoride – adult <i>(excluding prophylaxis)</i>	No copay	No copay	20%
1205 – Topical Fluoride – adult <i>(including prophylaxis)</i>	No copay	No copay	20%
1330 – Oral hygiene instructions	No copay	No copay	20%
1351 – Sealants – per tooth	\$5	No copay	20%
1510 – Space maintainers – fixed - unilateral	\$35	No copay	20%
1515 – Space maintainers – fixed - bilateral	\$35	No copay	20%
1520 – Space maintainers – removable - unilateral	\$40	No copay	20%
1525 – Space maintainers – removable - bilateral	\$40	No copay	20%
1550 – Recementation of space maintainer	\$5	No copay	20%

¹ For PPO Dental, members may choose between Dental Net or PPO Dental. Members may be covered under one program at a time; they may switch between options on a monthly basis.

² Copays reflect members' cost after calendar year deductible is satisfied.

³ For the third cleaning in a 12 month period, the copay is 80% of the dentist's usual fee.

Covered Services	Per Member Copay		
	Dental Net Program	PPO Dental Program ¹	
	Dental Net Dentists	PPO Dentists ²	Non-PPO Dentists ²
Restorative			
2110 – Fillings, amalgams – <i>one surface, primary</i>	No copay	20%	20%
2120 – Fillings, amalgams – <i>two surfaces, primary</i>	No copay	20%	20%
2130 – Fillings, amalgams – <i>three surfaces, primary</i>	No copay	20%	20%
2131 – Fillings, amalgams – <i>four or more surfaces, primary</i>	No copay	20%	20%
2140 – Fillings, amalgams – <i>one surface, permanent</i>	No copay	20%	20%
2150 – Fillings, amalgams – <i>two surfaces, permanent</i>	No copay	20%	20%
2160 – Fillings, amalgams – <i>three surfaces, permanent</i>	No copay	20%	20%
2161 – Fillings, amalgams – <i>four or more surfaces, permanent</i>	No copay	20%	20%
2330 – Resin – <i>one, surface, anterior</i>	No copay	20%	20%
2331/2332 – Resin – <i>two & three surfaces, anterior</i>	No copay	20%	20%
2335 – Resin – <i>four or more surfaces, anterior, or involving incisal angle</i>	\$10	20%	20%
2336 – Resin – based composite, <i>anterior – primary</i>	\$50	20%	20%
2337 – Resin – based composite, <i>anterior – permanent</i>	\$60	20%	20%
2380 – Resin – <i>one surface, posterior – primary</i>	\$30	20% ³	20% ³
2381 – Resin – <i>two surfaces, posterior – primary</i>	\$40	20% ³	20% ³
2382 – Resin – <i>three or more surfaces, posterior – primary</i>	\$50	20% ³	20% ³
2385 – Resin – <i>one surface, posterior – permanent</i>	\$50	20% ³	20% ³
2386 – Resin – <i>two surfaces, posterior – permanent</i>	\$65	20% ³	20% ³
2387 – Resin – <i>three or more surfaces, posterior – permanent</i>	\$75	20% ³	20% ³
2388 – Resin – based composite, <i>four or more surfaces, posterior – permanent</i>	\$85	20% ³	20% ³
2930/2931 – Prefabricated stainless steel crown – <i>primary/permanent tooth (provisional)</i>	\$10	20%	20%
2932 – Prefabricated resin crown (<i>provisional</i>)	\$10	20%	20%
2940 – Sedative filling	No copay	20%	20%
2951 – Pin retention – <i>per tooth, in addition to restoration</i>	\$10	20%	20%
Endodontics			
3110 – Pulp cap – <i>Direct (excluding final restoration)</i>	No copay	20%	20%
3120 – Pulp cap – <i>Indirect (excluding final restoration)</i>	No copay	20%	20%
3220 – Therapeutic pulpotomy (<i>excluding final restoration</i>)	\$5	20%	20%
3221 – Gross pulp debridement <i>primary & permanent teeth</i>	\$18	20%	20%
3310 – Anterior root canal therapy– <i>1 canal (excluding final restoration)</i>	\$80	20%	50%
3320 – Bicuspid root canal therapy– <i>2 canals (excluding final restoration)</i>	\$100	20%	50%
3330 – Molar root canal therapy– <i>3 canals (excluding final restoration)</i>	\$200	20%	50%
3332 – Incomplete endodontic therapy (<i>inoperable or fractured tooth</i>)	\$40	20%	50%
3346 – Retreatment of previous anterior root canal therapy	\$90	20%	50%
3347 – Retreatment of previous bicuspid root canal therapy	\$110	20%	50%
3348 – Retreatment of previous molar root canal therapy	\$135	20%	50%
3410 – Apicoectomy/periradicular surgery – <i>anterior</i>	\$90	20%	50%
3421 – Apicoectomy/periradicular surgery – <i>bicuspid (first root)</i>	\$90	20%	50%
3425 – Apicoectomy/periradicular surgery – <i>molar (first root)</i>	\$90	20%	50%
3426 – Apicoectomy/periradicular surgery – <i>each additional tooth</i>	\$40	20%	50%
3430 – Retrograde filling – <i>per root</i>	\$100	20%	50%
3910 – Surgical procedure for isolation of tooth with rubber dam	No copay	20%	50%
3950 – Canal preparation and fitting of preformed dowel or post	No copay	20%	50%
Periodontics			
4210 – Gingivectomy/Gingivoplasty – <i>per quadrant</i>	\$75	20%	50%
4211 – Gingivectomy/Gingivoplasty – <i>per tooth</i>	\$20	20%	50%
4220 – Gingival curettage, surgical – <i>per quadrant</i>	\$15	20%	50%
4260 – Osseous surgery – <i>per quadrant</i>	\$180	20%	50%
4341 – Periodontal scaling/root planing – <i>per quadrant</i>	\$20	20%	50%
4355 – Full mouth debridement to enable comprehensive periodontal evaluation/diagnosis	\$20	Not covered	Not covered
4910 – Periodontal maintenance procedures (<i>following active therapy</i>)	\$20	20%	50%
Oral Surgery			
7110/7120 – Single extraction/each additional tooth	No copay	20%	50%
7130 – Root removal – <i>exposed roots</i>	No copay	20%	50%
7210 – Surgical removal of erupted tooth	\$25	20%	50%
7220 – Removal of impacted tooth – <i>soft tissue</i>	\$30	20%	50%
7230 – Removal of impacted tooth – <i>partial bony</i>	\$65	20%	50%

¹ For PPO Dental, members may choose between Dental Net or PPO Dental. Members may be covered under one program at a time; they may switch between options on a monthly basis.

² Copays reflect members' cost after calendar year deductible is satisfied.

³ Procedures reimbursed at least expensive (amalgam) benefit level.

Covered Services	Per Member Copay		
	Dental Net Program	PPO Dental Program ¹	
	Dental Net Dentists	PPO Dentists ²	Non-PPO Dentists ²
Oral Surgery (continued)			
7240 – Removal of impacted tooth – <i>completely bony</i>	\$75 ³	20%	50%
7241 – Removal of impacted tooth – <i>completely bony, with unusual surgical</i>	\$75 ³	20%	50%
7250 – Surgical removal of residual tooth roots (<i>cutting procedure</i>)	\$45	20%	50%
7285 – Biopsy of oral tissue – <i>hard (bone, tooth)</i>	\$20 ⁴	20%	50%
7286 – Biopsy of oral tissue – <i>soft (all others)</i>	\$20 ⁴	20%	50%
7310 – Alveoloplasty in preparation for dentures, with extractions – <i>per quadrant</i>	\$65 ⁵	20%	50%
7320 – Alveoloplasty in preparation for dentures, without extractions – <i>per quadrant</i>	\$80 ⁵	20%	50%
7510 – Incision & drainage of abscess – <i>Intraoral soft tissue</i>	\$25	20%	50%
Prostodontics			
2510 – Inlay – metallic – <i>one surface</i>	\$65 ⁶	50%	50%
2520/6520 – Inlay – metallic – <i>two surfaces</i>	\$75 ⁶	50%	50%
2530/6530 – Inlay – metallic – <i>three or more surfaces</i>	\$85 ⁶	50%	50%
2542 – Onlay – metallic – <i>two surfaces</i>	\$125 ⁶	50%	50%
2543/6543 – Onlay – metallic – <i>three surfaces</i>	\$125 ⁶	50%	50%
2544/6544 – Onlay – metallic – <i>four or more surfaces</i>	\$125 ⁶	50%	50%
2740 – Crown – porcelain/ceramic substrate	\$200	50%	50%
2750 – Crown – porcelain fused to high noble metal	\$150 ⁶	50%	50%
2751 – Crown – porcelain fused to predominantly base metal	\$150	50%	50%
2752 – Crown – porcelain fused to noble metal	\$150 ⁶	50%	50%
2780 – Crown – cast high noble metal	\$150 ⁶	50%	50%
2781 – Crown – cast high predominantly base metal	\$150	50%	50%
2782 – Crown – cast noble metal	\$150 ⁶	50%	50%
2783 – Crown – porcelain/ceramic	\$150	50%	50%
2790 – Crown – Full cast high noble metal	\$150 ⁶	50%	50%
2791 – Crown – Full cast predominantly base metal	\$150	50%	50%
2792 – Crown – Full cast noble metal	\$150 ⁶	50%	50%
2810 – Crown – cast metallic	\$150 ⁶	50%	50%
2910 – Recement inlay	\$5	50%	50%
2920 – Recement crown	\$5	50%	50%
2950 – Core buildup, <i>including any pins</i>	\$15	50%	50%
2952 – Cast post and core <i>in addition to crown</i>	\$35	50%	50%
2953 – Each additional cast post (<i>same tooth</i>)	No copay	50%	50%
2954 – Prefabricated post and core <i>in addition to crown</i>	\$35	50%	50%
2955 – Post removal (<i>not in conjunction with endodontic therapy</i>)	\$10	50%	50%
2957 – Each additional prefab post (<i>same tooth</i>)	No copay	50%	50%
2970 – Temporary crown (<i>fractured tooth</i>)	\$20	50%	50%
6210 – Pontic – Cast high noble metal	\$150 ⁶	50%	50%
6211 – Pontic – Cast predominantly base metal	\$150	50%	50%
6212 – Pontic – Cast noble metal	\$150 ⁶	50%	50%
6240 – Pontic – Porcelain fused to high noble metal	\$150 ⁶	50%	50%
6241 – Pontic – Porcelain fused to predominantly base metal	\$150	50%	50%
6242 – Pontic – Porcelain fused to noble metal	\$150 ⁶	50%	50%
6245 – Pontic – Porcelain/Ceramic	\$200	50%	50%
6740 – Crown – Porcelain/ceramic	\$200	50%	50%
6750 – Crown – porcelain fused to high noble metal	\$150 ⁶	50%	50%
6751 – Crown – porcelain fused to predominantly base metal	\$150	50%	50%
6752 – Crown – porcelain fused to noble metal	\$150 ⁶	50%	50%
6780 – Crown – cast high noble metal	\$150 ⁶	50%	50%
6781 – Crown – cast high predominantly base metal	\$150	50%	50%
6782 – Crown – cast noble metal	\$150 ⁶	50%	50%
6783 – Crown – porcelain/ceramic	\$150	50%	50%
6790 – Crown – Full cast high noble metal	\$150 ⁶	50%	50%
6791 – Crown – Full cast predominantly base metal	\$150	50%	50%
6792 – Crown – Full cast noble metal	\$150	50%	50%
6930 – Recement fixed partial denture	\$5	50%	50%
6970 – Cast post and core <i>in addition to fixed partial denture retainer</i>	\$35	50%	50%

¹ For PPO Dental, members may choose between Dental Net or PPO Dental. Members may be covered under one program at a time; they may switch between options on a monthly basis.

² Copays reflect members' cost after calendar year deductible is satisfied.

³ Independent procedures copays cannot be combined.

⁴ Histopathological exam is not included and is not benefited.

⁵ In preparation for dentures.

⁶ Plus actual costs for noble/high (precious) metal not to exceed \$100.

Covered Services	Per Member Copay		
	Dental Net Program	PPO Dental Program ¹	
	Dental Net Dentists	PPO Dentists ²	Non-PPO Dentists ²
Prosthodontics (continued)			
6971 – Cast post as part of fixed partial denture retainer	\$35	50%	50%
6972 – Prefabricated post and core in addition to fixed partial denture retainer	\$35	50%	50%
6973 – Core buildup for retainer, including any pins	\$15	50%	50%
6976 – Each additional cast post (same tooth)	No copay	50%	50%
6977 – Each additional prefab post (same tooth)	No copay	50%	50%
5110/5120 – Complete denture (maxillary/mandibular)	\$200 ³	50%	50%
5130/5140 – Immediate denture (maxillary/mandibular)	\$200 ³	50%	50%
5211/5212 – Partial denture (maxillary/mandibular) – resin base (including clasps, rests)	\$225	50%	50%
5213/5214 – Partial denture (maxillary/mandibular) – cast metal framework with resin denture bases	\$250	50%	50%
5410/5411 – Adjust complete denture (maxillary/mandibular)	\$10	50%	50%
5421/5422 – Adjust partial denture (maxillary/mandibular)	\$10	50%	50%
5510 – Repair broken complete denture base	\$15	50%	50%
5520 – Replace missing or broken teeth – complete denture (each tooth)	\$15	50%	50%
5610 – Repair resin denture base	\$15	50%	50%
5620 – Repair cast framework	\$30	50%	50%
5630 – Repair or replace broken clasp	\$20	50%	50%
5640 – Replace broken teeth – (per tooth)	\$15	50%	50%
5650 – Add tooth to existing partial denture	\$15	50%	50%
5660 – Add clasp to existing partial denture	\$30	50%	50%
5710/5711 – Rebase complete denture (maxillary/mandibular)	\$80	50%	50%
5720/5721 – Rebase partial denture (maxillary/mandibular)	\$80	50%	50%
5730/5731 – Complete denture reline – chairside (maxillary/mandibular)	\$25	50%	50%
5740/5741 – Partial denture reline – chairside (maxillary/mandibular)	\$25	50%	50%
5750/5751 – Complete denture reline – laboratory (maxillary/mandibular)	\$50	50%	50%
5760/5761 – Partial denture reline – laboratory (maxillary/mandibular)	\$50	50%	50%
5820/5821 – Interim partial denture (maxillary/mandibular)	\$100	50%	50%
5850 – Tissue conditioning – per denture	\$30	50%	50%
5851 – Tissue conditioning – lower – per denture	\$30	50%	50%
Other Services			
Out-of-area emergency (limited to \$50 benefit for Dental Net)	No copay; all charges over \$50	20%	20%
9110 – Palliative emergency treatment of dental pain – minor procedure	\$5	20%	20%
9211 – Regional block anesthesia	No copay	20%	20%
9215 – Local anesthesia	No copay	20%	20%
9430 – Office visits for observation (during regularly scheduled hours)	No copay	No copay	20%
9440 – Office visits – after hours	\$45	No copay	20%
9630 – Other drugs and/or medicaments, (by report) – Broken appointments (less than 24 hours)	\$15 ⁴ \$25	20% Not covered	20% Not covered
Orthodontics			
24 months of usual and customary exclusive of records and retention fees			
8080 – Child through age 17	\$1,450	Not covered	Not covered
8090 – Adult age 18 and over	\$1,450	Not covered	Not covered
8660 – Pre-orthodontic visits and treatment plan	\$300	Not covered	Not covered
8680 – Orthodontic retention	\$275	Not covered	Not covered

¹ For PPO Dental, members may choose between Dental Net or PPO Dental. Members may be covered under one program at a time; they may switch between options on a monthly basis.

² Copays reflect members' cost after calendar year deductible is satisfied.

³ Either type of denture is an acceptable restoration; however, Dental Net benefits the first one placed, not both.

⁴ Not prescription drugs.

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive the Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

Choice Dental Exclusions & Limitations

LIMITED SERVICES – Applicable to Dental Net Program

Unauthorized Services. Dental services must be received from the member's participating dental office unless an exception is specifically authorized in writing by the member's participating dental office and/or Dental Net.

Oral Exams. Oral exams are limited to two per calendar year.

Prophylaxis. Prophylaxis procedures are limited to two treatments during any 12-month period. If a third prophylaxis is provided within the calendar year, it will be subject to a 80% copayment based on the participating dentist's usual fee.

Periodontal Procedures. Periodontal scaling and root planing and/or gingival curettage are limited to one course of therapy per quadrant during any 12-month period. Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis is limited to one course of treatment per lifetime.

Prosthetic Replacements. Partial dentures are not eligible for replacement within five years of original placement unless required as a result of additional tooth loss which cannot be restored by modification of the existing partial denture. Crowns, bridges, inlays and/or complete dentures are not eligible for replacement within five years of original placement.

Sealants. Sealants are limited to children under 16 years of age for permanent molars, unrestored. Treatment is limited to once every 36 months per tooth.

Denture Relines. Complete and/or partial denture relines or rebases are limited to one per denture during any 12-month period.

Precious Metals. The use of alloys with 25% or more noble metal content for any restorative procedure is considered optional and, if used, the additional cost for such alloy will be the member's responsibility.

Impactions. Removal of impacted teeth is limited to impactions which show radiographic evidence of a pathologic condition or for which the member experiences symptoms of infection, swelling or chronic pain.

Pediatric Annual Maximum. Pediatric dental services are limited to \$500 per calendar year for each child. Referral to a pedodontist will be considered for children to the age of 5. Charges in excess of \$500 will be the member's financial responsibility.

Porcelain on molars. If porcelain to metal crowns are placed on molars, an additional charge of \$75 per tooth will be charged.

Seven (7) or more crowns. If a treatment plan involves seven (7) or more crowns and/or fixed bridge units, an additional charge of \$125 per tooth or artificial tooth will be charged for all teeth and artificial teeth.

SERVICES NOT COVERED – Applicable to Dental Net Program

Not Acceptable Services. Any service or supply which is not a medically necessary service, as specified in the Evidence of Coverage (EOC).

Cosmetic Services. Dental services necessary solely for cosmetic reasons including, but not limited to, bleaching of non-vital discolored teeth, veneers and all other cosmetic procedures (unless specifically shown as a covered benefit).

Workers' Compensation. Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, under any workers' compensation or occupational disease law, even if the member does not claim those benefits.

Government Programs. Care or treatment which is obtained from or for which payment is made by any federal, state, county, municipal or other government agency, including any foreign government.

Fractures or Dislocations. Treatment of fractures or dislocations.

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.

Member Health Limitations. Charges for any dental treatment, which because of the member's general health or mental, emotional, behavioral, or physical limitations, cannot be performed in the participating dental office.

Lost or Stolen Dentures or Appliances. Replacement of lost or stolen dentures, bridgework or other dental appliances.

Services Provided Before or After the Term of the Member's Coverage. Dental treatment or expenses incurred in connection with any dental procedure started prior to the member's effective date. Dental treatment or expenses incurred after termination of the member's coverage, as specified as covered in the Evidence of Coverage (EOC).

Treatment by a Non-Participating Dentist. Any corrective treatment required as a result of dental services performed by a 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 Dental Net for completion.

Cysts and Neoplasms. Histopathological exams and/or the removal of tumors, cysts, neoplasms and foreign bodies.

Congenital or Developmental Malformations. Dental treatment or expenses incurred in connection with the correction of congenital or developmental malformations including, but not limited to, enamel hypoplasia, fluorosis, anodontia, supernumary or impacted teeth other than third molars.

Surgical Services. Tooth implantation or transplantation, orthognathic surgery, soft tissue or osseous grafts, hemisection or root amputation, apexification, alveoloplasty, vestibuloplasty or ostectomy procedures.

Prosthetic Services Age Limitations. Inlays, onlays, crowns, fixed bridges, or removable cast partials for members under 16 years of age. Space maintainers for members over age sixteen.

Experimental or Investigative Procedures. Procedures which are considered experimental or investigative or which are not widely accepted as proven and effective procedures within the organized dental community.

Implants. Dental procedures and charges incurred as part of implants or the removal of same. Fixed or removable prosthetics in conjunction with implants. Prophylaxis on implants.

Vertical Dimension and Attrition. Dental treatment or procedures (other than those for replacement of structure lost due to dental decay) required in conjunction with opening a bite or replacing tooth structure lost by wear, erosion or abrasion or due to bruxism. (Does not apply to alteration by removable prosthodontics.)

Periodontal Splinting. Dental treatment or expenses incurred in connection with periodontal splinting.

Treatment of the Joint of the Jaw. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues.

General Anesthesia. General anesthesia, inhalation sedation, intravenous sedation or intramuscular sedation.

Procedures Not Specified as Covered. Any procedure not specifically listed as a covered service.

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

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

Personalization, Characterization or Precision Attachments. Precision attachments, characterization or personalization of dentures is excluded.

Crown Lengthening. Crown exposure, ligation and crown lengthening are not covered.

Removal of Third Molars. Immature erupting third molars are not covered for extraction, i.e., tooth proceeding through a normal eruption process.

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

Denture Replacement. Dentures, full or partial-replacements will be made only if existing denture is five (5) years old, is unsatisfactory and cannot be made serviceable.

ORTHODONTIC EXCLUSIONS AND LIMITATIONS – Applicable to Dental Net Program

ORTHODONTIC LIMITATIONS– Applicable to Dental Net Program

Authorized Orthodontic Services. Orthodontic services must be received from the member's participating orthodontic office as specifically authorized and referred by Dental Net in writing.

Lifetime Maximum. Orthodontic treatment is limited to one full case (up to 24 months of standard orthodontic care) during the member's lifetime.

Loss of Coverage During Orthodontic Treatment. If the member's coverage under the plan ends, for any reason, while the member is still receiving orthodontic treatment during the 24 month treatment period, the member and NOT Dental Net will be responsible for the remainder of the cost for that treatment, at the contracted fee for the remaining number of months of treatment.

Orthodontic Consultation/Observation Fees. If treatment is not required or the member chooses not to start treatment after a diagnosis and consultation have been completed by the provider, the member may be charged a consultation fee of \$30 in addition to diagnostic record fees.

Orthodontic Retention Phase of Care. Retention services include initial fabrication, placement, observation, and adjustments of passive retention appliances for a 12-month period. The retention services fee of \$275 is the member's responsibility and is payable at the beginning of the retention phase of treatment. Retention services fees are subject to review and modification on an annual basis.

Orthodontic Services in Excess of 24 Months of Active Care. The member is required to pay the participating orthodontist of \$55 per month for each additional month of standard active orthodontic treatment provided beyond the 24 month period, but before the retention phase of treatment begins.

ORTHODONTIC EXCLUSIONS– Applicable to Dental Net Program

Changes in Treatment. Changes in treatment necessitated by an accident of any kind or patient noncompliance.

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

Orthodontic Retreatment. The retreatment of a previously treated orthodontic case (whether treated under this coverage, at fee-for-service, or under another benefit plan) is not covered.

Services Provided Before or After the Term of This Coverage. Orthodontic treatment begun prior to the member's effective date or after the termination of coverage.

Other Orthodontic Services. Services for braces, other orthodontic appliances, or orthodontic services, except as specifically stated in this coverage.

Orthodontic Treatment Incidental to Surgical Procedures. Orthodontic treatment in conjunction with oral surgical procedures including, but not limited to, orthognathic surgery.

Phase I Orthodontics/Orthopaedic/Orthodontic Treatment. Any Phase I treatment or orthopaedic/orthodontic treatment which may be deemed advantageous or necessary by the participating orthodontist prior to the 24 months or standard active treatment. Orthodontic treatment for malocclusions which, in the opinion of the participating orthodontist will not produce beneficial results.

Replacement of Orthodontic Appliances. Replacement of lost or stolen orthodontic appliances or repair of orthodontic appliances broken due to the member's negligence.

Special Orthodontic Appliances. Special types of orthodontic appliances which are considered cosmetic including, but not limited to, lingual or "invisible" braces, sapphire or clear braces, or ceramic braces.

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, ligation, correction of micrognathia or macrognathia, or repair of cleft palate.

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

SERVICES NOT COVERED – Applicable to Prudent Buyer Dental Plan Program

Duplicate Services or Supplies. Any covered services or supplies, or any services or supplies for which benefits would be provided under any other insurance policy, health care service plan or similar arrangement which the group sponsors to make dental benefits available.

Services Provided Before or After the Term of This Coverage. Services received before the insured person's effective date. Services received after the insured person's coverage ends, as specified as covered in the Certificate.

Experimental or Investigative Procedures. Any procedures which are considered experimental or investigative or which are not widely accepted as proven and effective procedures within the organized dental community.

Medically Necessary. Any services or supplies which are not medically necessary.

Workers' Compensation. Any work-related conditions if benefits are recovered or can be recovered either by adjudication, settlement or otherwise under any workers' compensation, employer's liability law or occupational disease law, even if the insured person does not claim those benefits.

Government Programs. Services provided by or payment made by any local, state, county or federal government agency, including Medicare and any foreign government agency.

No Charge Services. Services received for which no charge is made to the insured person or for which no charge would be made to the insured person in the absence of insurance coverage.

Results of War. Disease contracted or injuries sustained as a result of war, declared or undeclared, or from exposure to nuclear energy, whether or not the result of war.

Provider Related to Insured Person. Professional services received from a person who lives in the insured person's home or who is related to the insured person by blood or marriage.

Excess Expense. Any amounts in excess of covered dental expense or the Dental Benefit Maximums.

Professionally Acceptable Treatment. If more than one treatment plan would be considered medically necessary for a dental condition, any amount exceeding the cost of the least expensive professionally acceptable treatment plan is not covered.

Transfer of Care. If the insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, we shall be liable only for the amount we would have been liable for had one dentist rendered the services.

Hospital Charges. Hospital costs and any additional charges by the dentist for hospital treatment.

Services Not Included as a Covered Procedure. Services not specifically provided for by the plan unless they are similar in nature to an included procedure. In such event, the benefit payable will be based on the most nearly comparable services included.

Treatment By An Unlicensed Dentist. Charges for treatment by other than a licensed dentist or physician except charges for dental prophylaxis performed by a licensed dental hygienist, under the supervision and direction of a dentist.

Treatment of the Joint of the Jaw and/or Occlusion Services. Diagnosis, services, supplies or appliances provided in connection with any of the following:

- Any treatment to alter, correct, fix, improve, remove, replace, reposition, restore or otherwise treat the joint of the jaw (temporomandibular joint) or associated musculature, nerves and other tissues for any reason or by any means; or
- Any treatment, including crowns, caps and/or bridges to change the way the upper and lower teeth meet (occlusion); or
- Treatment to change vertical dimension (the space between the upper and lower jaw) for any reason or by any means including the restoration of vertical dimension because teeth have worn down.

Vertical Dimension and Attrition. Procedures requiring appliances or restorations (other than those for replacement of structure lost due to dental decay) that are necessary to alter, restore or maintain occlusion. These include, but are not limited to: changing the vertical dimension; replacing or stabilizing tooth structure lost by attrition, abrasion, or erosion; realignment of teeth; gnathological recording; occlusal equilibration; periodontal splinting.

Prosthetic Replacements. Replacement of an existing fixed or removable prosthesis, is not a benefit if the replacement occurs within five years of the original placement, unless the prosthesis is a stayplate used during the healing period for recently extracted anterior teeth. Replacement of a removable partial will be allowed if the partial is no longer useable, cannot be made serviceable and meets the five year requirement.

Orthodontics. Orthodontic braces, appliances and all related services.

Crown Replacements. Crowns, inlays, onlays or cast restorations on the same tooth in excess of once every five years of the original replacement.

Denture Repairs, Adjustments or Relines. Repairs, adjustments or relines of full or partial dentures, or other prostheses are not covered for a period of six months from the initial placement if they were paid for under this plan.

Lost or Stolen Dentures or Appliances. Replacement of existing full or partial dentures or prosthetic appliances which have been lost or stolen if replacement occurs within five years of the original placement.

Prosthetics (patients under 16 years old). Fixed bridges, removable cast partials, cast crowns, with or without veneers and inlays for persons under 16 years of age.

Implants. Implants (materials implanted into or on bone or soft tissue) or the removal of implants. However, if implants are provided in connection with a covered prosthetic appliance, we will allow the cost of a standard complete or partial denture, or a bridge, toward the cost of the implants and the prosthetic appliances.

Malignancies and Neoplasms. Services for treatment of malignancies and neoplasms.

Cosmetic Dentistry. Any services performed for cosmetic purposes, unless they are for correction of functional disorders or as a result of an accidental injury occurring while the insured person was covered for dental benefits under this plan.

Congenital or Developmental Malformation. Services to correct a congenital or developmental malformation including, but not limited to, cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (discoloration of the teeth) and anodontia (congenitally missing teeth).

X-rays. More than one set of full-mouth X-rays or its equivalent in a three-year period. Periapical x-rays submitted individually will be combined and paid up to the amount of a full mouth series.

Bite Wing X-rays. Bite wing X-rays in excess of 4 films for standard or 8 films for vertical bite wings twice in any 12-month period.

Prophylaxis or Periodontal Prophylaxis. Prophylaxis or periodontal prophylaxis procedures are limited to two treatments per calendar year. Periodontal prophylaxis must be preceded by active periodontal treatment, such as scaling and root planing or osseous (gum) surgery.

Sealants. Sealants are limited to children under 16 years of age for permanent unrestored molars. Treatment is limited to once every 36 months per tooth.

Prescription Drugs and Medications. Any prescribed drugs, pre-medication or analgesia.

Oral Hygiene. Oral hygiene instruction.

Space Maintainers. Use of space maintainers in excess of one treatment per lifetime, which includes one adjustment within six month of placement.

Periodontal Surgery. Periodontal surgery exceeding one time per quadrant in a 36-month period.

Root Canal Therapy. Root canal therapy in excess of one treatment per tooth for initial treatment and one retreatment per tooth.

Periodontal Scaling. Periodontal scaling exceeding one time per quadrant in a 24 month period.

Oral Surgery. Extraction of third molars (wisdom teeth) if the patient is under the age of 16.

Teeth Lost Prior to this Coverage. Teeth lost prior to coverage under this plan are not eligible for prosthetic replacement unless the prosthetic replacement replaces one or more eligible natural teeth lost during the term of this coverage.

Restorations. Restorations exceeding one every 12 months per surface per tooth for patients under the age of 19 and one every 36 months per surface per tooth for patients over the age of 19.

Precision Attachments. Precision attachments and the replacement of part of a precision attachment, magnetic retention or overdenture attachments.

Overdentures. Overdentures and related services, including root canal therapy on teeth supporting an overdenture.

Third Molars. The replacement of extracted or missing third molars/wisdom teeth.

Replacement of Existing Restorations. Replacement of existing restorations for any purpose other than restoring active decay.

Harmful Habit Appliances. Fixed and Removable appliances to inhibit thumb sucking.

Late Entrant Waiting Periods For PPO Dental Program,

If the insured person does not enroll in the Choice Dental Plan within 31 days of eligibility date, the following late entrant waiting periods will apply to certain PPO dental program services for:

- | | |
|---|-----------|
| ➤ Preventive and Diagnostic | None |
| ➤ Restorative, Periodontics, Endodontics, or Oral Surgery | 6 months |
| ➤ Prosthodontics | 12 months |

Third Party Liability. Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Coordination of Benefits. The benefits of this plan may be reduced if the member has any other group dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

Anthem Blue Cross is the trade name of Blue Cross of California. Independent Licensee of the Blue Cross Association. ® ANTHEM is a registered trademark. ® The Blue Cross name and symbol are registered marks of the Blue Cross Association.