



Dental Blue® Platinum Plus 100-80 Network 100 For Groups of 2-50 Employees

WELCOME TO DENTAL BLUE!

This benefit summary outlines the basic components of your plan, providing you with a quick reference of your dental plan benefits. For complete coverage details, please refer to the plan certificate.

Dental coverage you can count on.

Dental Blue lets you visit any licensed dentist or specialist you want—with costs that are normally lower when you choose one within the extensive national network.

— TO LOCATE A DENTAL PROVIDER —

Log on to anthem.com/ca and click Find a Doctor, then choose All Dental Products.

From the drop down menu, select the Dental Blue plan network name that is shown on your I.D. card. Next choose a provider type. You may choose from any of the Dental Blue provider types, however for greater potential savings, again select the Dental Blue plan network name that is shown on your I.D. card.

YOUR DENTAL BLUE PLAN AT-A-GLANCE

Annual Benefit Maximum – Calendar Year	\$2,000 per insured person	
Annual Deductible – Calendar Year	\$50 per insured person / up to \$150 per family	
Deductible Waived for Diagnostic and Preventive Services:	Yes	No
In-network	Yes	No
Out-of-network	No	No
DENTAL SERVICES	IN-NETWORK	OUT-OF-NETWORK
Following are examples of what is/is not covered by your plan:	Your plan pays:	Your plan pays:
Diagnostic and Preventive Services, for example:	100% of in-network fee	100% of out-of-network fee
• Periodic oral evaluation (0120)		
• Prophylaxis (cleaning) Adult (1110)		
• Prophylaxis (cleaning) Child (1120)		
• Bitewing X-rays – four films (0274)		
• Intraoral X-rays – complete series (0210)		
Restorative Services, for example:	90% of in-network fee	80% of out-of-network fee
• Filling, amalgam, two surfaces (2150)	90% of in-network fee	80% of out-of-network fee
• Oral surgery, e.g., tooth extraction, simple (7140)	90% of in-network fee	80% of out-of-network fee
• Endodontics, e.g., root canal, molar (3330)	90% of in-network fee	80% of out-of-network fee
• Periodontics, e.g., scaling and root planing, per quadrant (4341)	90% of in-network fee	80% of out-of-network fee
• Prosthodontics, e.g.:	60% of in-network fee	50% of out-of-network fee
crown, porcelain fused to high noble metal (2750)		
denture, complete, upper or lower (5110/5120)		
Orthodontic Services	50% of in-network fee	50% of billed charges
• Child Only / Adult and Child	Adult and child	Adult and child
• Ortho lifetime maximum benefits	up to \$1,500	up to \$1,500
Waiting Periods	None	None

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 the dental certificate. In the event of a discrepancy between the information contained in this benefit summary and that in the dental certificate, the dental certificate will prevail. CASGDBPP

Savings beyond your plan benefits

In addition to your covered benefits, we have negotiated lower costs for you on services that aren't covered by your plan, like porcelain veneers and other cosmetic dental procedures – even for services you may receive after you have reached your annual benefit maximum – provided that you receive services from a Dental Blue participating dentist.

In-network and out-of-network

Participating Providers are dentists who have contracted with us to provide dental care to our members at a negotiated rate.

With Dental Blue, there are three PPO network levels: Dental Blue 100, Dental Blue 200, and Dental Blue 300. Reimbursement to our contracted dentists is based on the network level they have agreed to participate in.

Regardless of which network your plan includes, you may see any Dental Blue dentist and still remain “in-network”.

- Dental Blue 100 members will usually save the most when they see a dentist in the Dental Blue 100 network.
- Dental Blue 200 members will usually save the most when they see a dentist in the Dental Blue 100 or 200 networks.
- Dental Blue 300 members may see any Dental Blue participating dentist and experience the same level of savings.

Non-Participating Providers are dentists who have not contracted with us and therefore may charge their usual fee for services they provide to you. This means that when you go “out-of-network” and see a non-participating provider, you will be responsible for any charges over the amount covered by your plan.

TO CONTACT US:

Call	Write	Email
<p>Refer to the toll-free number indicated on the back of your plan identification card or call (888) 209-7852 to speak in-person 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 at (888) 209-7852.</p>	<p>Refer to the back of your plan identification card for the claims submission address.</p> <p>Other correspondence may be sent to: PO Box 9066 Oxnard CA 93031</p>	<p>dentalhelp@anthem.com</p> <p>You may also visit our web site at: anthem.com/ca</p>

Limitations & Exclusions

<p>Limitations — Below is a partial listing of plan limitations. Please see your Certificate of Coverage for a full list.</p> <p><u>Diagnostic and Preventive Services</u></p> <p>Oral Evaluations (exam). Limited to two per year. Prophylaxis (cleaning). Limited to two per year. Bitewing X-rays. Limited to twice per year up to the age of 19, and once per year thereafter. Intraoral X-rays. Limited to two films per year. Complete Series X-rays (panoramic or full-mouth). Limited to one set every three years.</p> <p><u>Restorative Services</u></p> <p>Fillings. Limited to once per surface per tooth every 24 months. Crowns. Limited to once per tooth in a five year period. Removable Prosthodontics. Covered only for insured persons age 16 and over. Removable Complete (immediate or permanent) and Partial Dentures. Limited to once in five years. Fixed prosthodontics. Benefits are provided for the replacement of an existing bridge if it is five years old or older and cannot be made serviceable. Root Canal Therapy. Limited to one initial treatment per tooth during lifetime and one retreatment per tooth during lifetime. Coverage is for permanent teeth only. Gingivectomy or Gingivoplasty. Limited to once per quadrant in a three year period. Periodontal Scaling and Root Planing. Limited to once per quadrant every 24 months.</p> <p>ADDITIONAL LIMITATION FOR ORTHODONTIC SERVICES – if Orthodontia is included as a benefit of your plan.</p> <p>Orthodontia. Limited to one course of treatment during lifetime per insured person.</p>	<p>Exclusions — Below is a partial listing of non-covered services. Please see your Certificate of Coverage for a full list.</p> <p>Services Provided Before or After the Term of This Coverage. Services received before your effective date, unless otherwise specified in the plan certificate. Services received after your coverage ends, unless otherwise specified in the plan certificate.</p> <p>Not Medically Necessary. Any services, supplies or treatment which are not medically necessary (see <i>Definitions</i> in the plan certificate).</p> <p>Orthodontics (unless specified as being included as part of your plan benefits). Orthodontic braces, appliances and all related services.</p> <p>Cosmetic Dentistry. Any services performed for cosmetic purposes including, but not limited to, external bleaching, bleaching of non-vital discolored teeth, veneers, crowns on teeth not exhibiting pathology, and facings on crowns on posterior teeth.</p> <p>Prescription Drugs and Medications. Any prescribed drugs, pre-medication or analgesia. Any charge for nitrous oxide or local anesthesia when billed separately from a covered dental procedure.</p> <p>Extraction. Removal of immature erupting third molars and nonpathologic, asymptomatic third molars (wisdom teeth).</p> <p>Teeth Lost Prior to this Coverage. Any teeth lost prior to coverage under this plan are not eligible for prosthetic replacement.</p> <p>Treatment of the Joint of the Jaw and/or Occlusion Services.</p> <p>Implants. Materials implanted into or on bone or soft tissue and all adjunctive services.</p>
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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. CASGDBPP



Anthem Blue Cross Life and Health Insurance Company
Notice of Language Assistance

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មកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-800-627-8797 ។ សម្រាប់ជំនួយបន្ថែមទៀត
សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على
الرقم 1-800-627-8797. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357 Arabic.

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv
ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-800-627-8797. Yog xav tau
kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357. Hmong

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