

# BeneFits PPO Dental Plan

## Summary of Benefits



This is not a contract. All covered services are subject to the conditions, exclusions, qualifications, limitations, terms and provisions of the Anthem Blue Cross and Blue Shield BeneFits PPO Dental Certificate. For a covered dental service, this coverage will pay the applicable percentage or specified dollar amount (shown in the "Plan Pays (Maximum Allowable Amount)" column) of the Anthem Blue Cross and Blue Shield Dental maximum allowable for that service (up to the Annual Maximum). Please contact customer service to verify your dental coverage.

BENEFITS WILL BE PROVIDED ONLY FOR THE COVERED SERVICES SPECIFIED IN THIS SUMMARY OF BENEFITS. NO BENEFITS WILL BE PROVIDED FOR ANY OTHER SERVICES.

Annual Member Deductible	\$25 combined for Network and Non-Network providers
Family Coverage Deductible Limit	3 times Annual Member Deductible

Covered Services		Plan Pays (Maximum Allowable Amount)	
		Network Providers	Non-Network Providers
<b>Annual Maximum</b>		\$500 combined for network and non-network providers	
<b>Diagnostic and Preventive Services (deductible waived for in Network)</b>			
<b>Procedure</b>	<b>Description</b>		
*D0120	Periodic Oral Exam	100%	\$18
*D0140	Limited Oral Evaluation-Problem Focused	100%	\$28
*D0150	Comprehensive/Initial Oral Exam	100%	\$25
*D0160	Detailed and extensive oral evaluation - new or established patient	100%	\$49
*D0170	Re-evaluation - limited, problem focused	100%	\$28
*D0180	Comprehensive Periodontal Evaluation-new or established patient	100%	\$28
**D0210	Intraoral--Complete Series Including Bitewings	100%	\$60
D0220	Intraoral--Periapical--First Film	100%	\$13
D0230	Intraoral--Periapical--Each Additional Film	100%	\$8
D0240	Intraoral - Occusal film	100%	\$17
D0250	Extraoral - First film	100%	\$16
D0260	Extraoral - Each Additional Film	100%	\$10
D0270	Bitewing -- one Film	100%	\$16
D0272	Bitewings--two Films	100%	\$18
D0274	Bitewings--four Films	100%	\$26
D0277	Vertical Bitewings	100%	\$16
**D0290	Posterior-Anterior or Lateral skull and Facial Bone Survey Film	100%	\$50
**D0330	Panoramic Film	100%	\$36
**D0340	Cephalometric film	100%	\$38
D1110	Prophylaxis (teeth cleaning adult) (limited to 2 per Year)	100%	\$39
D1120	Prophylaxis (teeth cleaning child-through age 18) (limited to 2 per Year)	100%	\$30
D1201	Prophylaxis (teeth cleaning child-through age 18) with fluoride (limited to 2 per Year)	100%	\$35
D1203	Topical fluoride only (child through age 18) (limited to 2 per Year)	100%	\$14
D1204	Topical Appl. of Fluoride Excl. Prophy--Adult	Not covered	Not covered
D1205	Topical fluoride with Prophylaxis (teeth cleaning adult) (limited to 2 per Year)	100%	\$39

Covered Services		Plan Pays (Maximum Allowable Amount)	
		Network Providers	Non-Network Providers
<b>Fillings (deductible applies)</b>			
<b>Procedure</b>	<b>Description</b>		
D2140	Amalgam--One Surface Permanent or Primary	80%	\$42
D2150	Amalgam--Two Surfaces Permanent or Primary	80%	\$55
D2160	Amalgam--Three Surfaces Permanent or Primary	80%	\$72
D2161	Amalgam -- 4 or more surface, Permanent or Primary	80%	\$84
D2330	Resin--One Surface, Anterior	80%	\$42
D2331	Resin--Two Surfaces, Anterior	80%	\$55
D2332	Resin--Three Surfaces, Anterior	80%	\$72
D2335	Resin 4-surface incisal	80%	\$84
D2390	Resin-based composite crown, anterior	80%	\$85
***D2391	Resin-based composite-one surface posterior	80%	\$42
D2392	Resin-based composite-two surfaces posterior	80%	\$55
D2393	Resin-based composite-three surfaces posterior	80%	\$72
D2394	Resin-based composite-four surfaces posterior	80%	\$84
<b>All Other Services</b>		Not covered	Not covered

\* Exams are limited to two per Year.

\*\* Full mouth X-rays or its equivalent are limited to one set every three (3) Years.

\*\*\* If a tooth or teeth can be restored with amalgam (with the exception of composite resin on anterior teeth) any amount exceeding the cost of that material is not covered if another material is used. Anterior teeth exhibiting pathology eligible for composite restorations are central incisors, lateral incisors, cuspids and the facial surface of bicuspid.

**Anthem Blue Cross and Blue Shield Dental Customer Service: (888) 209-7852**