Dental Blue 300 PPO (Large Group 51+)
DNR/ISEP Effective Date: January 1, 2020

Annual Deductible	
Individual/Family	$ 50 Individual / $ 100 Family
Combined In and Out of Network	
Annual Maximum	$ 3,000
Maximum Carryover Provision	Included
Out of Network Reimbursement	70th Percentile

Services	PPO Dentists (In-network)	Non-PPO (Out-of-network)
Diagnostic and preventive • Oral evaluations, x-rays • Cleanings • Sealants and fluoride • Space maintainers	20%/No deductible	20%/No deductible
Minor restorative • Emergency palliative pain treatment • Amalgam restorations (fillings) • Composite restoration (fillings) • Sedative fillings • Pin retention	20% after deductible	20% after deductible
Oral surgery • Simple extractions • Removal of impacted teeth • General aesthesia	20% after deductible	20% after deductible
Endodontic services • Root Canal Therapy • Therapeutic pulpotomy • Direct pulp capping	20% after deductible	20% after deductible
Periodontal services • Scaling and root planing • Gingivectomy • Osseous surgery • Soft tissue grafts	20% after deductible	20% after deductible
Prosthodontic Services • Crowns • Removable complete and partial dentures • Post and core • Bridge repair • Implants • Missing Teeth	20% after deductible Covered Covered	20% after deductible Covered Covered
Orthodontic Services • Examinations • Records • Tooth guidance • Repositioning (straightening) of the teeth	40%/No deductible	40%/No deductible
Orthodontic Maximum	$3,700	
Orthodontic Age Limit	N/A	

Anthem

Choosing a dentist. You have the freedom to visit any dental provider. However, your Dentist choice Network Dentist or Non-Network Dentist can make a difference in the amount you pay. The choice is yours!

Filing a claim. Claims should be submitted to Anthem Dental P.O. Box 9274, Oxnard CA 93031.

No Cost Share (NCS) means no deductible, copayment or coinsurance up to the maximum allowable amount. However, a member may be responsible for any balance due after the plan payment, including, but not limited to, benefits that reflect No Cost Share

Limitations & Exclusions

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.

Limitations — Below is a partial listing of some of the limitations. Please see Certificate for full list:

- Oral Evaluations. Limited to two per year.
- Prophylaxis or Periodontal Maintenance Procedure. Limited to two treatments per year, singly or in combination.
- Fluoride treatments. lLimited to two per year for children up to age 19.
- X-rays. Limited to one set of full-mouth x-rays or its equivalent once every five years. Periapical x-rays are limited to 4 films per year.
- Sealants. Limited to children under 16 years of age for permanent unrestored first and second molars. Treatment is limited to two applications per tooth per lifetime.
- Space Maintainers. Limited to once per quadrant per lifetime for children up to age 16. Includes all adjustments within six months of placement.
- Palliative Emergency Treatment. Limited to twice per year.
- Sedative Filling. Limited to once per tooth in any 24-month period.
- Amalgam or Composite Resin Restorations (fillings). Limited to once per surface per tooth every 24 months.
- Periodontal Scaling and Root Planing. Limited to once per quadrant every 24 months.
- Periodontal Surgery. Limited to once per quadrant in any three years.
- Crown Lengthening. Limited to once per tooth per lifetime.
- Root Canal Therapy. Root canal therapy limited to one initial treatment per tooth and one retreatment per tooth – for permanent teeth only.
- General Anesthesia. Covered only when used in conjunction with covered oral surgical procedures.

Exclusions — Below is a partial listing of non-covered services. Please see Certificate for full list:

- Experimental or investigative procedures
- Cosmetic dentistry
- Procedures requiring appliances or restorations to alter, restore or maintain occlusion
- Harmful habit appliances
- Charges for lost or stolen dentures or appliances or for a duplicate prosthetic device or appliance
- Prescribed drugs, pre-medication or analgesia (includes nitrous oxide)
- Charges for the extraction of immature erupting third molars and nonpathologic, asymptomatic third molars
- Malignancies and neoplasms and the removal of tumors, cysts, and foreign bodies
- Charges for tobacco counseling, oral hygiene instruction, dietary planning or behavior management
- Treatment for temporomandibular joint disorder (TMJ)
- Occlusal guards, adjustments
- Hospital costs
- Replacement of teeth missing prior to coverage under this Plan
- Services or treatments that are not medically necessary
- Charges for missed or cancelled appointments
- Prosthodontic services
- Orthodontic services

Note: The Certificate of Coverage may contain variations by state due to specific state regulatory requirements.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature	Date