## Dental Blue 300 PPO (Large Group 51+)

### DNR/ISEP

**Effective Date:** July 1, 2013

### Annual Deductible
- **Individual/Family:** $50 Individual / $100 Family
- **Combined In and Out of Network:**

### Annual Maximum
- **Out of Network Reimbursement:** Included

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