Your Summary of Benefits
Dental Net® Dental HMO Plan 2000C

WELCOME TO YOUR DENTAL PLAN! This benefit summary outlines the basic components of Anthem's Dental Net DHMO Plans – providing you with a quick reference of your dental benefits. For complete coverage details, please refer to the Combined Evidence of Coverage and Disclosure Form.

Dental coverage you can count on

With our Dental Net DHMO plans, there are no annual benefit maximums or deductibles, and there are set copayments for services you receive. You choose a dental office and primary dentist from our directory of participating dentists. The dentist you select will provide all routine dental services and arrange for any specialty care you may need. After enrollment, you will receive a member ID card listing your selected dental office and phone number. You may transfer from one participating dentist to another if you choose. To do so, just call or write us by the 15th of the month before the month you wish to transfer. If approved, your transfer request will be effective on the first of the month after we receive it.

Emergency dental treatment for the international traveler

As an Anthem dental member, you and your eligible, covered dependents automatically have access to the International Emergency Dental Program.+ With this program, you may receive emergency dental care from our listing of credentialed, English-speaking dentists while traveling or working nearly anywhere in the world.

+The International Emergency Dental Program is managed by DeCare Dental, an independent company offering dental-management services to Anthem Blue Cross. To learn more about the program, please visit the International Emergency Dental Web site at www.decare.com/internationalDentalProgram.do.

Promoting healthy mouths for members who are pregnant or diabetic

If you are pregnant or living with diabetes, you may receive one additional dental cleaning or periodontal maintenance procedure per year. To learn more about this program and obtain an extra cleaning benefit form, please visit www.anthem.com/ca/mydental and click on Extra Cleanings near the center of the page.

YOUR DENTAL NET PLAN AT A GLANCE

The chart below shows nearly 300 services and corresponding Current Dental Terminology (CDT) codes † covered by our Dental Net plans.

Annual Benefit Maximum: No annual maximum	**Annual Deductible:** No deductible

CDT Code	Benefit	Copay
Diagnostic Services		
D0120	Periodic oral evaluation – established patient	$0
D0140	Limited oral evaluation – problem focused	$0
D0150	Comprehensive oral evaluation – new or established patient	$0
D0160	Detailed and extensive oral evaluation – problem focused, by report	$0
D0170	Re-evaluation – limited, problem focused (established patient; not postoperative visit)	$0
D0180	Comprehensive periodontal evaluation – new or established patient	$0
D0210	Intraoral X-rays – complete series of radiographic images	$0
D0220	Intraoral X-rays – periapical, first radiographic image	$0
D0230	Intraoral X-rays – periapical, each additional radiographic image	$0
D0240	Intraoral X-rays – occlusal radiographic image	$0
D0250	Extraoral X-rays – first radiographic image	$0
D0260	Extraoral X-rays – each add'l radiographic image	$0
D0270	Bitewing X-rays – single radiographic image	$0
D0272	Bitewing X-rays – two radiographic images	$0
D0273	Bitewing X-rays – three radiographic images	$0
D0274	Bitewing X-rays – four radiographic images	$0
D0277	Vert. bitewings – seven to eight radiographic images	$0
D0330	Panoramic radiographic image	$0
D0350	Oral/facial photographic images	$0
D0415	Collection of microorganisms for culture and sensitivity	$0
D0425	Caries susceptibility tests	$0
D0431	Adjunctive prediagnostic test that aids in detection of mucosal abnormalities, including premalignant and malignant lesions; not to include cytology or biopsy procedures	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
Preventive Services		
D1110	Teeth cleaning (prophylaxis) – adult, two per calendar year	$0
D1120	Teeth cleaning (prophylaxis) – child, two per calendar year	$0

†Copyright ® American Dental Association.

CDT Code	Benefit	Copay
D1206	Topical application of fluoride varnish	$0
D1208	Topical application of fluoride (formerly CDT Codes D1203 and D1204)	$0
D1310	Nutritional counseling for control of dental disease	$0
D1320	Tobacco counseling for the control and prevention of oral disease	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant, per tooth, through age 15	$0
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	$5
D1510	Space maintainer (fixed – unilateral)	$0
D1515	Space maintainer (fixed – bilateral)	$0
D1520	Space maintainer (removable – unilateral)	$0
D1525	Space maintainer (removable – bilateral)	$0
D1550	Re-cementation of space maintainer	$0
D1555	Removal of fixed space maintainer by dentist who did not place appliance	$0
Restorative Services		
D2140	Amalgam (silver colored) filling, one surface, primary or permanent	$0
D2150	Amalgam (silver colored) filling, two surfaces, primary or permanent	$0
D2160	Amalgam (silver colored) filling, three surfaces, primary or permanent	$0
D2161	Amalgam (silver colored) filling, four or more surfaces, primary or permanent	$0
D2330	Resin-based composite (tooth colored) filling, one surface, anterior (front) tooth	$0
D2331	Resin-based composite (tooth colored) filling, two surfaces, anterior (front) tooth	$0
D2332	Resin-based composite (tooth colored) filling, three surfaces, anterior (front) tooth	$0
D2335	Resin-based composite (tooth colored) filling, four or more surfaces or involving incisal angle, anterior (front) tooth	$0
D2390	Resin-based composite (tooth colored) crown, anterior (front) tooth	$10
D2391	Resin-based composite (tooth colored) filling, one surface, posterior (back) tooth	$10
D2392	Resin-based composite (tooth colored) filling, two surfaces, posterior (back) tooth	$20
D2393	Resin-based composite (tooth colored) filling, three surfaces, posterior (back) tooth	$30
D2394	Resin-based composite (tooth colored) filling, four or more surfaces, posterior (back) tooth	$40
D2510	Inlay – metallic, one surface	$55*
D2520	Inlay – metallic, two surfaces	$70*
D2530	Inlay – metallic, three or more surfaces	$70*
D2542	Onlay – metallic, two surfaces	$75*
D2543	Onlay – metallic, three surfaces	$75*
D2544	Onlay – metallic, four or more surfaces	$75*
D2610	Inlay – porcelain/ceramic, one surface	$85*
D2620	Inlay – porcelain/ceramic, two surfaces	$85*
D2630	Inlay – porcelain/ceramic, three or more surfaces	$85*
D2642	Onlay – porcelain/ceramic, two surfaces	$75*
D2643	Onlay – porcelain/ceramic, three surfaces	$75*
D2644	Onlay – porcelain/ceramic, four or more surfaces	$75*
D2650	Inlay – resin-based composite, one surface	$85
D2651	Inlay – resin-based composite, two surfaces	$85
D2652	Inlay – resin-based composite, three+ surfaces	$85

CDT Code	Benefit	Copay
D2662	Onlay – resin-based composite, two surfaces	$75
D2663	Onlay – resin-based composite, three surfaces	$75
D2664	Onlay – resin-based composite, four+ surfaces	$75
D2710	Crown – resin-based composite (indirect)	$105
D2712	Crown – 3/4 resin-based composite (indirect)	$105
D2720	Crown – resin with high noble metal	$105*
D2721	Crown – resin with predominantly base metal	$105
D2722	Crown – resin with noble metal	$105*
D2740	Crown – porcelain/ceramic substrate	$95*
D2750	Crown – porcelain fused to high noble metal	$90*
D2751	Crown – porcelain fused to predominantly base metal	$90*
D2752	Crown – porcelain fused to noble metal	$90*
D2780	Crown – 3/4 cast high noble metal	$105*
D2781	Crown – porcelain/ceramic substrate	$105*
D2782	Crown – 3/4 cast noble metal	$105*
D2783	Crown – 3/4 porcelain/ceramic	$105*
D2790	Crown – full cast high noble metal	$85*
D2791	Crown – full cast predominantly base metal	$85
D2792	Crown – full cast noble metal	$85*
D2794	Crown – titanium	$85*
D2799	Provisional crown – further treatment or completion of diagnosis necessary prior to final impression	$25
D2910	Re-cement inlay, onlay or partial coverage restoration	$0
D2915	Re-cement cast or prefab post and core	$0
D2920	Re-cement crown	$0
D2929	Prefabricated porcelain/ceramic crown, primary tooth	$20*
D2930	Prefabricated stainless steel crown, primary tooth	$10
D2931	Prefabricated stainless steel crown, permanent tooth	$10
D2932	Prefabricated resin crown	$20
D2940	Protective restoration	$0
D2950	Core buildup, including any pins	$20
D2951	Pin retention – per tooth, in addition to restoration	$0
D2952	Post and core in addition to crown, indirectly fabricated	$25
D2953	Each add'l indirectly fabricated post – same tooth	$0
D2954	Prefabricated post and core in addition to crown	$23
D2955	Post removal	$0
D2957	Each additional prefabricated post-same tooth	$0
D2960	Labial veneer, resin laminate/chairside	$195
D2961	Labial veneer, resin laminate/laboratory	$250
D2962	Labial veneer, porcelain laminate/laboratory	$275*
D2970	Temporary crown (fractured tooth)	$20
D2971	Additional procedures to construct new crown under existing partial denture framework	$30
D2980	Crown repair necessitated by restorative material failure	$0

CDT Code	Benefit	Copay
D2981	Inlay repair necessitated by restorative material failure	$0
D2982	Onlay repair necessitated by restorative material failure	$0
D2983	Veneer repair necessitated by restorative material failure	$0
D2990	Resin infiltration of incipient smooth surface lesions	$0
Endodontic Services		
D3110	Pulp cap – direct (excluding final restoration)	$0
D3120	Pulp cap – indirect (excluding final restoration)	$0
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$10
D3221	Pulpal debridement, primary and permanent teeth	$15
D3310	Endodontic (root canal) therapy, anterior (front) tooth (excluding final restoration)	$65
D3320	Endodontic (root canal) therapy, bicuspid tooth (excluding final restoration)	$75
D3330	Endodontic (root canal) therapy, molar (three or four canals, excluding final restoration)	$130
D3346	Retreatment of previous root canal therapy – anterior (front)	$75
D3347	Retreat of previous root canal therapy (bicuspid)	$85
D3348	Retreat of previous root canal therapy (molar)	$145
D3410	Apicoectomy/periradicular surgery – anterior (front)	$85
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	$85
D3425	Apicoectomy/periradicular surgery – molar (first root)	$85
D3426	Apicoectomy/periradicular surgery – additional root	$35
D3430	Retrograde filling (per root)	$60
Periodontic Services		
D4210	Gingivectomy/gingivoplasty – four+ contiguous (adjoining) teeth/tooth-bounded spaces per quadrant	$55
D4211	Gingivectomy/gingivoplasty – one to three contiguous (adjoining) teeth/tooth-bounded spaces per quadrant	$15
D4212	Gingivectomy/gingivoplasty to allow access for restorative procedure – per tooth	$15
D4260	Osseous surgery (including flap entry and closure) – four+ contiguous (adjoining) teeth/tooth-bounded spaces per quadrant	$145
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous (adjoining) teeth or tooth-bounded spaces per quadrant	$90
D4268	Surgical revision procedure, per tooth	$0
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$20
D4342	Periodontal scaling and root planing, one to three teeth per quadrant during any calendar year	$10
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$15
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$20
D4910	Periodontal maintenance	$13
D4920	Unscheduled dressing change, by someone other than treating dentist	$0

CDT Code	Benefit	Copay
Prosthodontic Services (Removable)		
D5110	Complete denture upper – maxillary	$125
D5120	Complete denture lower – mandibular	$125
D5130	Immediate denture upper – maxillary	$125
D5140	Immediate denture lower – mandibular	$125
D5211	Maxillary (upper) partial denture – resin base (including any conventional clasps, rests and teeth)	$100
D5212	Mandibular (lower) partial denture – resin base (including any conventional clasps, rests and teeth)	$100
D5213	Maxillary (upper) partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$130
D5214	Mandibular (lower) partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$130
D5225	Maxillary (upper) partial denture – flexible base (including any clasps, rests and teeth)	$275
D5226	Mandibular (lower) partial denture – flexible base (including any clasps, rests and teeth)	$275
D5410	Adjust complete denture – maxillary (upper)	$0
D5411	Adjust complete denture – mandibular (lower)	$0
D5421	Adjust partial denture – maxillary (upper)	$0
D5422	Adjust partial denture – mandibular (lower)	$0
D5510	Repair broken complete denture base	$0
D5520	Replace missing or broken teeth – complete denture (each tooth)	$0
D5610	Repair resin denture base	$0
D5620	Repair cast framework	$0
D5630	Repair or replace broken clasp	$0
D5640	Replace broken teeth – per tooth	$0
D5650	Add tooth to existing partial denture	$0
D5660	Add clasp to existing partial denture	$0
D5670	Replace all teeth and acrylic on cast metal framework – maxillary (upper)	$75
D5671	Replace all teeth and acrylic on cast metal framework – mandibular (lower)	$75
D5710	Rebase complete maxillary (upper) denture	$0
D5711	Rebase complete mandibular (lower) denture	$0
D5720	Rebase maxillary (upper) partial denture	$0
D5721	Rebase mandibular (lower) partial denture	$0
D5730	Reline complete maxillary (upper) denture (chairside)	$0
D5731	Reline complete mandibular (lower) denture (chairside)	$0
D5740	Reline maxillary (upper) partial denture (chairside)	$0
D5741	Reline mandibular (lower) partial denture (chairside)	$0

CDT Code	Benefit	Copay
D5750	Reline complete maxillary (upper) denture (lab)	$0
D5751	Reline complete mandibular (lower) denture (lab)	$0
D5760	Reline maxillary (upper) partial denture (lab)	$0
D5761	Reline mandibular (lower) partial denture (lab)	$0
D5810	Interim complete denture – maxillary (upper)	$125
D5811	Interim complete denture – mandibular (lower)	$125
D5820	Interim partial denture – maxillary (upper)	$40
D5821	Interim partial denture – mandibular (lower)	$40
D5850	Tissue conditioning – maxillary (upper)	$0
D5851	Tissue conditioning – mandibular (lower)	$0
D5860	Overdenture – complete, by report	$195
D5861	Overdenture – partial, by report	$195
Prosthodontic Services (Fixed)		
D6205	Pontic (bridge) – indirect resin-based composite	$100
D6210	Pontic (bridge) – cast high noble metal	$100*
D6211	Pontic (bridge) – cast predominantly base metal	$100*
D6212	Pontic (bridge) – cast noble metal	$100*
D6214	Pontic (bridge) – titanium	$100*
D6240	Pontic (bridge) – porcelain fused to high noble metal	$125*
D6241	Pontic (bridge) – porcelain fused to predominantly base metal	$125*
D6242	Pontic (bridge) – porcelain fused to noble metal	$125*
D6245	Pontic (bridge) – porcelain/ceramic	$125*
D6250	Pontic (bridge) – resin w/ high noble metal	$100*
D6251	Pontic (bridge) – resin w/ predominantly base metal	$100*
D6252	Pontic (bridge) – resin w/ noble metal	$100*
D6253	Provisional pontic (bridge) – further treatment or completion of diagnosis necessary prior to final impression	$100
D6545	Retainer – cast metal for resin-bonded fixed prosthesis	$55
D6548	Retainer – porcelain/ceramic for resin-bonded fixed prosthesis	$55*
D6600	Inlay – porcelain/ceramic , two surfaces	$85*
D6601	Inlay – porcelain/ceramic three or more surfaces	$85*
D6602	Inlay – cast high noble metal, two surfaces	$70*
D6603	Inlay – cast high noble metal, three or more surfaces	$70*
D6604	Inlay – cast predominantly base metal, two surfaces	$70*
D6605	Inlay – cast base metal, three or more surfaces	$70*
D6606	Inlay – cast noble metal, two surfaces	$70*
D6607	Inlay – cast noble metal, three or more surfaces	$70*
D6608	Onlay – porcelain/ceramic, two surfaces	$75*
D6609	Onlay – porcelain/ceramic, three or more surfaces	$75*
D6610	Onlay – cast high noble metal, two surfaces	$75*
D6611	Onlay – cast high noble metal, three or more surfaces	$75*
D6612	Onlay – cast predominantly base metal, two surfaces	$75*
D6613	Onlay – cast predominantly base metal, three or more surfaces	$75*
D6614	Onlay – cast noble metal, two surfaces	$75*

CDT Code	Benefit	Copay
D6615	Onlay – cast noble metal, three or more surfaces	$75*
D6624	Inlay – titanium	$70*
D6634	Onlay – titanium	$70*
D6710	Crown – indirect resin-based composite	$100
D6720	Crown – resin w/ high noble metal	$100*
D6721	Crown – resin w/ predominantly base metal	$100*
D6722	Crown – resin w/ noble metal	$100*
D6740	Crown – porcelain/ceramic	$125*
D6750	Crown – porcelain fused to high noble metal	$125*
D6751	Crown – porcelain fused to predominately base metal	$125*
D6752	Crown – porcelain fused to noble metal	$125*
D6780	Crown – 3/4 cast high noble metal	$125*
D6781	Crown – 3/4 cast predominately base metal	$125*
D6782	Crown – 3/4 cast noble metal	$125*
D6783	Crown – 3/4 porcelain/ceramic	$125*
D6790	Crown – full cast high noble metal	$125*
D6791	Crown – full cast predominantly base metal	$125*
D6792	Crown – full cast noble metal	$125*
D6794	Crown – titanium	$125*
D6930	Re-cement fixed partial denture	$0
D6940	Stress breaker	$70
D6980	Fixed partial denture (bridge) repair necessitated by restorative material failure	$0
Oral and Maxillofacial Surgery Services		
D7111	Extraction, coronal remnants – deciduous tooth	$0
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$20
D7220	Removal of impacted tooth – soft tissue	$40
D7230	Removal of impacted tooth – partial bony	$50
D7240	Removal of impacted tooth – completely bony	$60
D7241	Removal of impacted tooth – completely bony w/unusual surgical complications	$70
D7250	Surgical removal of residual tooth roots (cutting procedure)	$30
D7280	Surgical access of an unerupted tooth	$70
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$5
D7283	Placement of device to facilitate eruption of impacted teeth	$15
D7285	Biopsy of oral tissue – hard (bone, tooth)	$30
D7286	Biopsy of oral tissue – soft	$30
D7288	Brush biopsy – transepithelial sample collection	$35
D7310	Alveoplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$20
D7311	Alveoplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$20
D7320	Alveoplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$30
D7321	Alveoplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$30
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	$150
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	$250

CDT Code	Benefit	Copay
D7471	Removal of lateral exostosis (maxilla or mandible)	$50
D7472	Removal of torus palatinus	$50
D7473	Removal of torus mandibularis	$50
D7485	Surgical reduction of osseous tuberosity	$40
D7510	Incision and drainage of abscess – intraoral soft tissue	$20
D7511	Incision and drainage of abscess – intraoral soft tissue, complicated (includes drainage of multiple fascial spaces)	$20
D7520	Incision and drainage of abscess – extraoral soft tissue	$25
D7521	Incision and drainage of abscess – extraoral soft tissue, complicated (includes drainage of multiple fascial spaces)	$75
D7910	Suture of recent small wounds up to 5 cm	$50
D7960	Frenulectomy (also frenectomy or frenotomy) – separate procedure not incidental to another	$40
D7963	Frenuloplasty	$20
D7970	Excision of hyperplastic tissue (per arch)	$55
D7971	Excision of pericoronal gingiva	$25
Orthodontic Services**		
D8030	Limited treatment of the adolescent dentition	$1,025
D8040	Limited treatment of the adult dentition	$1,025
D8070	Comprehensive treatment of the transitional dentition	$1,695
D8080	Comprehensive treatment of the adolescent dentition	$1,695
D8090	Comprehensive treatment of adult dentition	$1,895

CDT Code	Benefit	Copay
D8660	Pre-orthodontic treatment visit	$0
D8680	Orthodontic retention (placement of retainers	$200
Other Services		
D9110	Palliative (emergency) treatment of dental pain – minor procedures	$0
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0
D9220	Deep sedation/general anesthesia – first 30 minutes	$130
D9221	Deep sedation/general anesthesia – add'l 15 minutes	$55
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$15
D9241	Intravenous conscious sedation/analgesia – first 30 minutes	$125
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes	$55
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	$0
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	$0
D9440	Office visit after regularly scheduled hours	$25
D9630	Other drugs and/or medications, by report	$30
D9930	Treatment of postsurgical complications – unusual circumstances, by report	$30
D9940	Occlusal guard, by report	$50

*Plus costs for noble or high noble metal, not to exceed $125, and/or costs for porcelain, not to exceed $100
**Twenty-four months of standard orthodontic care, exclusive of records/retention fees.

Participating Dental Net Dental HMO Providers

Participating Dental Net providers are dentists who have contracted with us to provide you with dental services covered under this plan. Your selected dentist will diagnose and treat most of your dental conditions and will coordinate all your dental care – referring you to specialists when necessary. With the exception of out-of-area emergency services, all of your dental care needs must be provided by, or coordinated through, your selected dental office in order to be covered by your dental plan. Services provided by nonparticipating providers (dentists who are not contracted as part of the Dental Net Dental HMO network) **are not covered** under this plan, except for limited coverage of emergency services.

Finding a dentist is easy – We have a large network of dentists from which to choose.

To select a dentist by name or location:

- Go to www.anthem.com/ca and click on **FIND A DOCTOR** (Dentist, Pharmacy, or Hospital)
- Call Dental Customer Service at 888-209-7852

To Contact Us:

Call	Write	Email
Call the toll-free number on the back of your plan ID card or call 888-209-7852 to speak with a U.S.-based customer service representative during normal business hours. If you are calling after hours, we may still be able to assist you with our interactive voice-response system at 888-209-7852.	Refer to the back of your ID card for the claims submission address.	dentalhelp@anthem.com You may also visit our Web site at: **anthem.com/ca**

Limitations and Exclusions

Limitations – Below is a partial listing of plan limitations. Please see your Evidence of Coverage for a full list.

Unauthorized Services Dental services must be received from the member's participating dental office unless an exception is specifically authorized by the member's participating dental office and/or Anthem Blue Cross, in writing.
Prophylaxis Prophylaxis procedures are limited to two treatments per calendar year. Pregnant women and persons with diabetes will be eligible for a third prophylaxis per calendar year. These are called "Enhanced Benefits" and description of how to use your enhanced benefit is found in your Evidence of Coverage.
Periodontal Procedures Periodontal scaling and root planing is limited to one course of therapy per quadrant during every calendar year.
Prosthodontic Replacement
1. Partial dentures are not eligible for replacement within five (5) years of original placement unless required as a result of additional tooth loss, which cannot be restored by modification of the existing partial denture.
2. Crowns, bridges, inlays and/or complete dentures are not eligible for replacement within five (5) years of original placement.
Denture Relines Complete and/or partial denture relines or rebases are limited to one per denture every calendar year.
Precious Metals The use of alloys/noble metal for any restorative procedure is considered optional and if used, the additional cost for such alloy will be the Members financial responsibility up to $125.
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.
Out-of-area emergency dental care is up to $100.
Professionally Acceptable Treatment In cases where multiple acceptable methods of treatment exist, the least expensive professionally acceptable treatment is considered the covered benefit.
The following are in addition to the standard exclusions and limitations:
Periodontal Procedures Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis is limited to one course of treatment per lifetime.
(same as Precious Metals above)
Sealants Sealants are limited to children under sixteen (16) years of age for permanent unrestored molars. Treatment is limited to once per tooth every 36 months.
Oral Exams Oral exams are limited to two (2) per calendar year.
Porcelain on molars If porcelain to metal crowns are placed on molars, as additional charge of $100.00 per tooth will be chargeable to the member.
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.

Exclusions – Below is a partial listing of noncovered services. Please see your Evidence of Coverage for a full list.

Cosmetic Services Dental care that is only to improve your appearance when tooth structure and function are satisfactory and no pathologic conditions (decay) exist.
Workers' Compensation Any condition for which benefits of any nature are recoverable, whether by adjudication or settlement, under any workers' compensation or occupational disease law, even if you did not claim those benefits.
If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, benefits will be provided subject to our right of recovery and reimbursement under California Labor Code Section 4903.
Government Programs Care or treatment which is obtained from, or for which payment is made by any Federal, State, or other government agency, including any foreign government.
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 dental care that cannot be performed in the participating dental office because of your general health, mental or emotional behavior, or physical limitations.
Lost or Stolen Dentures or Appliances Replacement of crowns, dentures, bridgework, or other dental appliances that have been lost, stolen or damaged due to misuse or neglect..
Services Provided Before or After Your Term of Coverage Dental care you receive either before your effective date or after your coverage ends.
Dental Care Outside of the Dental Net Network Except as provided in the section How To Get Emergency Care When You Need It of your Evidence of Coverage, services given by a dentist or dental office that is not part of the Dental Net network will not be covered. Also, we will not cover services that are needed as a result of dental care given by a dentist or dental office that is not a part of the Dental Net network.
Congenital (hereditary) or Developmental Malformations Treatment of congenital or developmental malformations including, but not limited to, enamel hypoplasia, flourosis, supernumerary 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, vestibuloplasty, or ostectomy procedures.
Prosthetic Services Age Limitations Space maintainers for members over age twelve (12).
Not Generally Accepted Procedures which are considered experimental or investigative or which are not generally accepted standards of dental practice within the organized dental community.
Implants Dental procedures and charges incurred as part of implants or the removal of implants. Fixed or removable prosthetics in conjunction with implants. Prophylaxis on implants.
Extensive Oral Rehabilitation Dental treatment or procedures requiring or associated with fixed prosthodontic restorations (other than for replacement of structure lost due to dental decay).
Vertical Dimension and Attrition Procedures requiring (other than those for replacement of structure lost due to dental decay) that are necessary to alter, restore or maintain occlusion. Exclusion does not apply to alteration by removable prosthodontics.
Periodontal Splinting Services for or relating to periodontal splinting.
Treatment of the Joint of the Jaw Diagnosis or treatment by any method of any condition related to the jaw joint (temporomandibular joint) or associated musculature, nerves and other tissues.
Not Medically Necessary Services or supplies that are not considered medically necessary.
General Anesthesia and IV Sedation Covered only when given with the removal on or more impacted teeth (completely bony). Subject to preauthorization.
Services Not Listed. Dental care services that are not specifically listed in the Schedule of Copayments in your Evidence of Coverage.
Crown Lengthening Crown exposure, ligation and crown lengthening are not covered.
Removal of Third Molars Immature erupting third molars and non-pathologic asymptomatic third molars are not covered for extraction.
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 and cannot be made serviceable.
Poor Prognosis Endodontic treatment, periodontal surgery, or crown/bridge work is not covered on teeth with questionable, guarded or poor prognosis. We will allow for observation or extraction and prosthetic replacement.
Precision Attachments Services for precision attachments.
Orthodontic Pretreatment Any treatment or services that your dentist deems necessary or advantageous in order to begin standard orthodontic treatment.

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. The in-network dentists mentioned in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of Anthem Blue Cross.

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