PART 3 WHAT IS COVERED

A. DEDUCTIBLE

Deductible is the amount of charges you will pay before We begin to pay for certain Covered Services.

1. Your Yearly Deductible for Covered Services is $25.00. During each Year, you are responsible for all expense's incurred up to the Deductible amount. Only Covered Services up to the Contracted Amount for Network Dentists count toward the Deductible. For Non-Network Dentists, only Covered Services up to the amounts stated in the Benefit Schedule count toward the Deductible. Amounts over the amounts stated in the Benefit Schedule that a Non-Network Dentist may charge you won't count towards the Deductible. **The Deductible does not apply to diagnostic and preventive services when performed by a Network Dentist.**

B. YEARLY MAXIMUM BENEFIT

All dental benefits are limited to a maximum payment of $500.00 for expense incurred by you during a Year.

C. PAYMENT

Payment is provided as follows for Covered Services incurred. All payments are subject to any maximum amounts, limitations and exclusions as indicated in this Policy. If a Network Dentist provides services, any billed amount above the Contracted Amount will be a savings to you. Network Dentists have agreed to accept the Contracted Amount as payment in full. Non-Network Dentists have no such agreement with Anthem, therefore, they may bill You for any amounts over the amounts stated in the Benefit Schedule.

BENEFITS WILL BE PROVIDED ONLY FOR THE SERVICES SPECIFIED IN THIS BENEFIT SCHEDULE. NO BENEFITS WILL BE PROVIDED FOR ANY THING ELSE.

At a Network Dentist, benefits will be paid for Covered Services as follows:

- 100% of the Contracted Amount you incur for diagnostic and preventive services (see Benefit Schedule below for a list of Covered Services) (Deductible is waived); and
- 80% of the Contracted Amount you incur in excess of the Deductible for fillings (see Benefit Schedule below for a list of Covered Services).

At a Non-Network Dentist:

Benefits will be paid as indicated in the following Benefit Schedule **(after the Deductible has been satisfied).** The Policy pays the specified amount or actual fee charged by the Dentist, whichever is lower. Please note, you may have a greater share of the costs if services are performed by a Non-Network Dentist.

BENEFIT SCHEDULE

Diagnostic and Preventive care

Procedure Code and Brief Description		At a Non-Network Dentist, the Plan Pays After Deductible
*D0120	Periodic oral exam	$18
*D0140	Limited oral exam-problem focused	$28
*D0150	Initial oral exam	$25
*D0160	Detailed and extensive oral exam-new or established patient	$49
*D0170	Re-evaluation exam-limited, problem focused	$28
*D0180	Comprehensive periodontal exam-new or established patient	$28
**D0210	Full mouth X-rays	$60
D0220	Single (periapical) X-rays – first film	$13
D0230	Single X-rays – additional films	$8
D0240	Single X-rays – Occusal	$17
D0250	Extraoral-first film	$16
D0260	Extraoral-each additional film	$10
D0270	Bitewing X-ray – single film	$16
D0272	Bitewing X-rays – two films	$18
D0274	Bitewing X-rays – four films	$26
D0277	Vertical bitewing X-rays	$16
**D0290	Posterior-anterior or lateral skull and facial bone survey film	$50
**D0330	Panoramic X-ray	$36
**D0340	Cephalometric film	$38
D1110	Prophylaxis (teeth cleaning adult) (limited to 2 per Year)	$39
D1120	Prophylaxis (teeth cleaning child-through age 18) (limited to 2 per Year)	$30
D1201	Prophylaxis (teeth cleaning child-through age 18) with fluoride (limited to 2 per Year)	$35
D1203	Topical fluoride only (child through age 18) (limited to 2 per Year)	$14
D1205	Topical fluoride with Prophylaxis (teeth cleaning adult) (limited to 2 per Year)	$39

***** Exams are limited to two per Year.

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

Fillings

After the Deductible has been satisfied, benefits will be paid for fillings as specified in the following Benefit Schedule. Please note, you may have a greater share of the costs if services are performed by a Non-Network Dentist.

Procedure Code and Brief Description		At a Non-Network Dentist, the Plan Pays After Deductible
D2140	Amalgam filling – one surface, primary or permanent	$42
D2150	Amalgam filling –two surfaces, primary or permanent	$55
D2160	Amalgam filling – three surfaces, primary or permanent	$72
D2161	Amalgam filling – four or more surfaces, primary or permanent	$84
D2330	Resin-based composite filling – one surface, anterior	$42
D2331	Resin-based composite filling – two surfaces, anterior	$55
D2332	Resin-based composite filling – three surfaces, anterior	$72
D2335	Resin-based composite filling – four surfaces, incisal	$84
D2390	Resin-based composite crown, anterior	$85
***D2391	Resin-based composite filling – one surface, posterior	$42
***D2392	Resin based composite filling – two surfaces, posterior	$55
***D2393	Resin based composite filling – three surfaces, posterior	$72
***D2394	Resin based composite filling – four surfaces, posterior	$84

*** 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 bicuspids.

PART 4 WHAT IS NOT COVERED

No benefits are provided for or in connection with the following. They are considered to be exclusions and limitations, which include, but are not limited to the following:

Unlisted Services: Services not specifically listed in the Benefit Schedule section of this Policy.

Excess Amounts: Any amounts in excess of the maximum amounts stated in the PART called WHAT IS COVERED.

Any amounts which exceed the **Allowable Charge** as determined by Anthem.

Expenses Before Coverage Begins: Services received before your Effective Date or during an inpatient stay that began before your Effective Date.

End of Coverage: Services received after your coverage ends.

Services For Which You Are Not Legally Obligated To Pay: Services for which no charge is made to you in the absence of insurance coverage.

Services for someone other than the Policyholder: Any person other than the Policyholder, including but not limited to the Policyholder's dependent's such as spouse, domestic partner, legal ward, natural child, adopted child or child placed for adoption.

Workers' Compensation: Any condition for which benefits are recovered or can be recovered, either by any workers' compensation law or similar law even if you do not claim those benefits, except for corporate officers who may opt out of Workers' Compensation coverage. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to worker's compensation law or similar law, We will provide the benefits of this plan for such conditions, subject to a conditional claims payment during an appeal process if a reimbursement agreement is signed.

Governmental Service: Any services provided by a local, state, county or federal government agency including any foreign government.

Services From Relatives: Professional services received from a person who lives in your home or who is related to you by blood, marriage or adoption.

Cosmetic Dentistry: Any services performed for cosmetic purposes (including but not limited to external bleaching, bleaching of non-vital discolored teeth, composite restorations, veneers, crowns on teeth not exhibiting pathology and facings on crowns on posterior teeth).

Clinical Research: Services or supplies which are part of clinical research unless We otherwise allow.

Complications of Non-Covered Services: Complications arising from non-Covered Services and supplies. Examples of non-Covered Services include but are not limited to, Cosmetic Surgery, operations and procedures which are determined to be Experimental/Investigational.

Over the Counter Products: Items available without a prescription.

Charges for treatment by other than a licensed dentist, except charges for dental prophylaxis performed by a licensed dental hygienist.

Orthodontic services, braces appliances and all related services.

Q. **Diagnosis or Treatment of the Joint of the Jaw and/or Occlusion:** Services, supplies or appliances provided in connection with:

1. Any treatment to alter, correct, fix, improve, remove, replace, reposition, restore or otherwise treat the joint of the jaw (temporomandibular joint) or associated musculature, nerves and other tissues for any reason or by any means; or
2. Any treatment, including crowns, and/or bridges to change the way the upper and lower teeth meet (occlusion); or
3. Treatment to change vertical dimension (the space between the upper and lower jaw) for any reason or by any means including the restoration of vertical dimension because teeth have worn down due to attrition, abrasion, abfraction, erosion or bruxism.

R. **Procedures requiring restorations** (other than those for replacement of structure loss from tooth decay) that are necessary to alter, restore or maintain occlusions. These include but are not limited to:

1. Changing the vertical dimension.
2. Replacing or stabilizing lost tooth structure by attrition, abrasion, abfraction, erosion or bruxism.
3. Realignment of teeth.
4. Gnathological recording.
5. Occlusal equilibration.
6. Periodontal splinting.

S. **Oral examinations exceeding two visits per Year.**

Prophylaxis (teeth cleaning) exceeding two treatments per Year.

More than one set of full-mouth X-rays or its equivalent in a three (3) Year period.

Fluoride applications:

- if you are over eighteen (18) years of age.
- exceeding two visits per Year.

Periapical and bite wing x-rays submitted singly will be combined and paid up to the amount of a full mouth series and are subject to the full-mouth x-ray limitation. No more than two (2) bite wing x-ray series for standard in a Year will be covered. No more than eight (8) films for vertical bite wings in a 36 month period will be covered.

Correction of congenital or development malformation including but not limited to supernumery and/or over retained deciduous teeth, cleft palate, maxillary or mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).

Y. **Fillings exceeding one per Year per surface per tooth** if you are under the age of 19 and one every three (3) Years per surface per tooth if you are over the age of 19.

Z. **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 bicuspids.

AA. **Replacement of existing fillings** for any purpose other than restoring active decay.

BB. **Transfer of care:** If a Policyholder transfers from the care of one Dentist to that of another Dentist during the course of treatment, or if more than one Dentist renders services for one dental procedure, Anthem shall be liable only for the amount it would have been liable for had one Dentist rendered the services.

CC. **Prescribed drugs, pre-medication or analgesia (including nitrous oxide) are excluded.**

DD. **Oral hygiene instruction.**

EE. **Malignancies and Neoplasms:** Services for treatment of malignancies and neoplasms are not Covered Services.

FF. **All hospital costs and any additional fees charged by the Dentist for hospital treatment.**

GG. **Implants:** (Materials implanted into or on bone or soft tissue), or the removal of implants are not benefits under this Policy.

HH. **Services or Supplies That Are Not Medically Necessary.**

II. **Services for oral surgery,** for example, tooth extractions.

Services for endodontics, for example, root canals. **Endodontics** means the branch of dentistry dealing with diseases of the tooth pulp.

KK. **Services for periodontics**, for example, scaling and root planning. **Periodontics** is the dental specialty of treating periodontal disease.

LL. **Services for prosthodontics,** for example, crowns**. Prosthodontics** is the branch of dentistry dealing with the construction of artificial appliances for the mouth, especially for the purpose of replacing missing teeth with bridges and dentures.

MM. **Space maintainers.** Space maintainers are appliances that are designed to prevent tooth movement.

NN. **Experimental/Investigational.** Services or supplies which are Experimental/Investigational or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigational service or supply, as determined by Anthem.

OO. **Sealants**.