Dental Net®
Plan 550

We're Committed To Providing You With Great Dental Care Option

Dental care is an important part of your comprehensive health care coverage and well-being. Anthem Blue Cross knows being protected with dental coverage is an important safeguard for you and your family. We have been dedicated to providing you and your family with premier dental coverage for more than thirty years.

Diagnostic and preventive services are the key to maintaining good dental health. Dental coverage is designed to assure that you receive regular preventive care. With routine examinations, minor dental problems can be diagnosed and treated before major, more costly problems occur. Anthem Blue Cross' Dental Net plan can be instrumental in your long-term dental health.

Dental Net is a dental HMO that offers one of the most extensive networks of quality dentists in California. When you use your selected Dental Net dentist, you will receive a higher benefit level. With Dental Net there are no deductibles and no copayments for diagnostic or preventive services, which keeps your out-of-pocket expenses to a minimum.

Simply select the office and primary dentist that is most convenient to your home or work. Your selected dental office will provide all routine dental services and arrange for any specialty care you may need. Because each eligible family member may choose his or her own dentist, you and your family will enjoy greater flexibility and freedom of choice.

Dental Net Advantages

Some important advantages when using your Dental Net plan include:

- Easy to use
- Diagnostic and preventive care at no cost to members
- No claim forms
- No deductibles or annual maximums for most dental services
- Orthodontic coverage
- Referral to specialists from your primary dentist

Your Dental Net Plan

When you enroll in Dental Net, you'll be asked to select a participating dental office and primary dentist from a statewide directory of Dental Net network dentists. With the exception of out-of-area emergency services and certain specialty services, all of your dental care needs must be provided by, or coordinated through, your selected dental office and primary dentist. After enrollment, you will receive a member ID card listing your selected participating dental office and the phone number.

Your First Visit

Because preventive dental care is so important, Dental Net provides benefits at no cost for X-rays and two teeth cleanings per year. Soon after enrollment, you should call your participating dental office for an initial diagnostic examination. X-rays will usually be taken at this time to determine the overall condition of your teeth. Through routine check-ups, minor dental problems can often be diagnosed and treated before they become major problems.

We encourage you to call your participating dental office whenever you need dental care. Please note that Dental Net does not limit the number of times you can see your dentist.

Customer Service

A Customer Service representative is available to answer your questions and inquiries at (800) 627-0004.

Dental Net Benefits

There is no deductible with Dental Net, however, some procedures require a copayment that you will need to pay at the time of service. Please refer to the amount on the chart.

Continuing Coverage

As required by federal law, certain restrictions and conditions apply to the right to continue coverage and are described in your Evidence of Coverage (EOC).

Covered Services	Per Member Copay
Diagnostic	
150 – Oral examinations	No copay
210 – X-rays – intraoral – complete	No copay
220 – X-rays – periapical – first film	No copay
270 – X-rays – bitewing – single film	No copay
274 – X-rays – bitewing – four films	No copay
Preventive	
1110 – Prophylaxis – adult	No copay
1120 – Prophylaxis – child	No copay
1201 – Topical Fluoride – child *(including prophylaxis)*	No copay
Restorative	
2110 – Fillings – amalgams *(including polishing)* – one surface, primary	No copay
2140 – Fillings – amalgams *(including polishing)* – one surface, permanent	No copay
2330 – Resin or composite restorations – one surface, anterior-permanent	No copay
2930 – Prefabricated stainless steel crown, primary or permanent	No copay
Endodontics	
3110 – Pulp cap *(direct)*	No copay
3220 – Therapeutic Pulpotomy	No copay
3310 – Anterior Root canal therapy – 1 canal	$60
3320 – Bicuspid Root canal therapy – 2 canals	$80
3330 – Molar Root canal therapy – 3 canals	$100
Periodontics	
4210 – Gingivectomy/Gingivoplasty – per quadrant	$60
4211 – Gingivectomy/Gingivoplasty – per tooth	$9
4260 – Osseous surgery – per quadrant	$120
4341 – Perio-scaling/root planing – per quadrant	$18
Oral Surgery	
7110 – Single extraction/Additional tooth	No copay
7220 – Impaction – soft tissue	$30
7230 – Impaction – partial bony	$40
7240 – Impaction – full bony	$50
Prosthodontics	
1510 – Space maintainers – fixed-unilateral	$45
1515 – Space maintainers – fixed-bilateral	$45
2750 – Crown – porcelain fused to high noble metal	$120
2954 – Post/core – prefab.	$20
5110/5120 – Complete denture *(maxillary/mandibular)*	$140
5213/5214 – Partial denture *(maxillary/mandibular)*	$160
5730/5731 – Complete denture reline – chairside *(maxillary/mandibular)*	$20
5520 – Complete denture – broken tooth repair *(each tooth)*	$10
Other Services	
Out-of-area emergency *(limited to $50 benefit)*	No copay; all charges over $50
9440 – Office visits – after hours	$45
9215 – Local anesthesia	No copay
Orthodontics	
24 months of usual and customary exclusive of records and retention fees	
8080 – Child through age 17	$1,450
8090 – Adult age 18 and over	$1,850

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive the Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

Dental Net Exclusions & Limitations
(Applicable to all Dental Net Plans, Except Plans 650 & 750)

LIMITED SERVICES

Unauthorized Services. Dental services must be received from the member's participating dental office unless an exception is specifically authorized in writing by the member's participating dental office and/or Dental Net.

Oral Exams. Oral exams are limited to two per calendar year.

Prophylaxis. Prophylaxis procedures are limited to two treatments during each calendar year.

Periodontal Procedures. Periodontal scaling and root planing and/or gingival curettage are limited to one course of therapy per quadrant during any 12-month period.

Prosthodontic Replacements. Partial dentures are not eligible for replacement within five years of original placement unless required as a result of additional tooth loss which cannot be restored by modification of the existing partial denture. Crowns, bridges, inlays and/or complete dentures are not eligible for replacement within five years of original placement.

Denture Relines. Complete and/or partial denture relines or rebases are limited to one per denture during any 12-month period.

Precious Metals. The use of alloys with 25% or more noble metal content for any restorative procedure is considered optional and, if used, the additional cost for such alloy will be the member's responsibility.

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.

Professionally Acceptable Treatment. In cases where multiple acceptable methods of treatment exist, the least expensive professionally acceptable treatment is considered the covered benefit.

Pediatric Annual Maximum. Pediatric dental services are limited to $500 for each child. Referral to a pedodontist will be considered only for children to the age of 5. Charges in excess of $500 will be the member's financial responsibility.

SERVICES NOT COVERED

Cosmetic Services. Dental services necessary solely for cosmetic reasons including, but not limited to, bleaching of non-vital discolored teeth and bonding procedures (unless specifically shown as a covered benefit).

Workers' Compensation. Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, under any workers' compensation or occupational disease law, even if the member does not claim those benefits.

Result of Nuclear Energy. Conditions that result from any release of nuclear energy, whether or not a result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

Government Programs. Care or treatment which is obtained from or for which payment is made by any federal, state, county, municipal or other government agency, including any foreign government.

Fractures or Dislocations. Treatment of fractures or dislocations.

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 any dental treatment, which because of the member's general health or mental, emotional, behavioral, or physical limitations, cannot be performed in the participating dental office.

Lost or Stolen Dentures or Appliances. Replacement of lost crowns, lost or stolen dentures, bridgework or other dental appliances.

Services Provided Before or After the Term of the Member's Coverage. Dental treatment or expenses incurred in connection with any dental procedure started prior to the member's effective date. Dental treatment or expenses incurred after termination of the member's coverage, as specified as covered in the Evidence of Coverage (EOC).

Treatment by a Non-Participating Dentist. Any corrective treatment required as a result of dental services performed by a non-participating dentist while this coverage is in effect, and any dental services started by a non-participating dentist will not be the responsibility of the participating dental office or Dental Net for completion.

Cysts and Neoplasms. Histopathological exams and/or the removal of tumors, cysts, neoplasms and foreign bodies.

Congenital or Developmental Malformations. Dental treatment or expenses incurred in connection with the correction of congenital or developmental malformations including, but not limited to, enamel hypoplasia, fluorosis, endodontia, supernumary 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, alveoloplasty, vestibuloplasty or ostectomy procedures.

Prosthetic Services Age Limitations. Inlays, onlays, crowns, fixed bridges, or removable cast partials for members under 16 years of age. Space maintainers for members over age sixteen years of age.

Experimental or Investigative Procedures. Procedures which are considered experimental or investigative or which are not widely accepted as proven and effective procedures within the organized dental community.

Implants. Dental procedures and charges incurred as part of implants or the removal of same. 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) when part of extensive oral rehabilitation or reconstruction. Five (5) or more crowns subject to our approval.

Vertical Dimension and Attrition. Dental treatment or procedures (other than those for replacement of structure lost due to dental decay) required in conjunction with altering vertical dimension or replacing tooth structure lost by attrition, erosion or abrasion or due to bruxism.

Periodontal Splinting. Dental treatment or expenses incurred in connection with periodontal splinting.

Treatment of the Joint of the Jaw. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues.

Not Medically Necessary. A dental treatment plan which in the opinion of the participating dentist and/or Dental Net is not medically necessary or will not produce beneficial results.

General Anesthesia. General anesthesia, inhalation sedation, intravenous sedation or intramuscular sedation.

Composite Resin and Porcelain Restorations. Porcelain or composite labial veneers for fixed prosthodontics, posterior to the second bicuspid and composite fillings posterior to the cuspid. Any material other than base metal is optional and will be an additional cost to the member.

Procedures Not Specified as Covered. Any procedure not specifically listed as a covered service.

Drugs or Dispensing of Drugs. Plan does not cover prescription drugs as a dental benefit.

Questionable, Guarded or Poor Prognosis. Teeth with questionable, guarded or poor prognosis are not covered for endodontic treatment, periodontal surgery or crown and bridge. Dental Net will allow for observation or extraction and prosthetic replacement.

Personalization, Characterization or Precision Attachments. Precision attachments, characterization or personalization of dentures is excluded.

Crown Lengthening. Crown exposure, ligation and crown lengthening are not covered.

Removal of Third Molars. Immature erupting third molars are not covered for extraction, i.e., tooth proceeding through a normal eruption process.

Primary Restorations. Gold, porcelain or resin fillings on primary teeth are excluded.

Build Ups. Amalgam, composite or cement build-ups are not a separate benefit, but are considered part of the completed restoration.

Denture Replacement. Dentures, full or partial-replacements will be made only if existing denture is five (5) years old, is unsatisfactory and cannot be made serviceable.

ORTHODONTIC EXCLUSIONS AND LIMITATIONS

ORTHODONTIC LIMITATIONS

Authorized Orthodontic Services. Orthodontic services must be received from the member's participating orthodontic office as specifically authorized and referred by Dental Net in writing.

Lifetime Maximum. Orthodontic treatment is limited to one full case (up to 24 months of standard orthodontic care) during the member's lifetime.

Loss of Coverage During Orthodontic Treatment. If the member's coverage under the plan ends, for any reason, while the member is still receiving orthodontic treatment during the 24 month treatment period, the member and NOT Dental Net will be responsible for the remainder of the cost for that treatment, at the participating orthodontist's customary and reasonable fee, prorated for the number of months of treatment remaining.

Orthodontic consultation/Observation Fees. If treatment is not required or the member chooses not to start treatment after a diagnosis and consultation have been completed by the provider, the member may be charged a consultation fee of $30 in addition to diagnostic record fees.

Orthodontic Retention Phase of Care. Retention services include initial fabrication, placement, observation, and adjustments of passive retention appliances for a 12-month period. The retention services fee of $250 is the member's responsibility and is payable at the beginning of the retention phase of treatment. Retention services fees are subject to review and modification on an annual basis.

Orthodontic Services in Excess of 24 Months of Active Care. The member is required to pay the participating orthodontist of $55 per month for each additional month of standard active orthodontic treatment provided beyond the 24 month period, but before the retention phase of treatment begins.

ORTHODONTIC EXCLUSIONS

Changes in Treatment. Changes in treatment necessitated by an accident of any kind.

Myofunctional Therapy. Myofunctional therapy and related services. (Myofunctional therapy involves the use of muscle exercises as an adjunct to orthodontic mechanical correction of malocclusion.)

Orthodontic Records. Orthodontic records, including, but not limited to, cephalometric tracing, photographs, study models and diagnostic radiographs.

Orthodontic Retreatment. The retreatment of a previously treated orthodontic case (whether treated under this coverage, at fee-for-service, or under another benefit plan) is not covered.

Services Provided Before or After the Term of This Coverage. Orthodontic treatment begun prior to the member's effective date or after the termination of coverage.

Other Orthodontic Services. Services for braces, other orthodontic appliances, or orthodontic services, except as specifically stated in this coverage.

Orthodontic Treatment Incidental to Surgical Procedures. Orthodontic treatment in conjunction with oral surgical procedures including, but not limited to, orthognatic surgery.

Phase I Orthodontics/Orthopaedic/Orthodontic Treatment. Any Phase I treatment or orthopaedic/orthodontic treatment which may be deemed advantageous or necessary by the participating orthodontist prior to the 24 months or standard active treatment. Orthodontic treatment for malocclusions which, in the opinion of the participating orthodontist will not produce beneficial results.

Replacement of Orthodontic Appliances. Replacement of lost or stolen orthodontic appliances or repair of orthodontic appliances broken due to the member's negligence.

Special Orthodontic Appliances. Special types of orthodontic appliances which are considered cosmetic including, but not limited to, lingual or "invisible" braces, sapphire or clear braces, or ceramic braces.

Surgical Procedures Incidental to Orthodontic Treatment. Surgical procedures incidental to orthodontic treatment including, but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate.

T.M.J. or Hormonal Imbalance Orthodontic Services. Treatment related to the joint of the jaw (temporomandibular joint, TMJ) and/or hormonal imbalance.

Third Party Liability. Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Coordination of Benefits. The benefits of this plan may be reduced if the member has any other group dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

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