Dental care is an important part of your comprehensive health care coverage and well-being. Anthem Blue Cross Life and Health Insurance Company knows being protected by dental insurance is an important safeguard for you and your family.

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 set in. Your National Dental PPO Plan can be instrumental in your long-term dental health.

National Dental PPO Advantages
Some important advantages when using your National Dental PPO plan:

- You can enjoy negotiated rates and no payment due at time of service (excluding any applicable copayments)
- Over 75,000 network dentists to choose from
- No claim forms

How The Plan Works
Your National Dental PPO Plan is a preferred provider organization (PPO) plan from Anthem Blue Cross Life and Health Insurance Company. Dentists have agreed to charge discounted, negotiated rates to those enrolled in the National Dental PPO Plan. They agree to accept this rate as payment in full and not to bill you for the difference. (Please be aware that you are responsible for deductibles, copayments and charges for services not covered.) In addition to discounted fees, these PPO dentists also agree to submit claims for you and take responsibility for any needed treatment authorizations.

Your participating dentist will complete and submit the claim form to us. We will pay the benefits of the plan directly to the dentist.

The National Dental PPO Plan provides you with the freedom of choice to select virtually any licensed dentist. However, if you choose a National Dental PPO Plan participating dentist, you also take advantage of negotiated discounts and a more generous reimbursement schedule. Simply select your dentist from our extensive PPO national network of dental providers.

If you use a dentist who does not participate in the National PPO Plan network, you may pay more for dental care and will be responsible for an annual deductible and for your portion of the covered services plus charges in excess of the covered expense. To maximize your benefits when you require specialty care, ask your attending dentist to refer you to a specialist who is a member of the National PPO Plan network.

Whenever you need dental care, simply call and make an appointment. When you use the National Dental PPO Plan network, your dentist will submit claims for covered expense to us and we will reimburse the dentist directly.

Participating Providers
After enrolling in the National Dental PPO Plan, you will receive a Directory of participating dentists. If you have a particular dentist in mind and he or she is not in the directory, you may call the customer service telephone number on your ID card to see if the dentist has recently joined the network. Please note that it is your responsibility to verify that the dentists you use are members of the National Dental PPO Plan provider network.

Make Efficient Use of Network Resources
To maximize your benefits, when you require specialized care, ask your dentist to refer you to a member of the National Dental PPO Plan network.
Late Entrant Waiting Period
If you do not enroll in your dental plan within 31 days of your eligibility date, you will be subject to a Late Entrant Waiting Period. This means that you will not be covered immediately for certain dental services. Details of the Late Entrant Waiting Period can be found in the Exclusions and Limitations section of this document.

Dental Deductible
A deductible is the amount of money you pay for a covered dental expense prior to benefits being paid under the plan. Only charges that are considered covered dental expenses will apply toward satisfaction of the deductible. Please refer to the deductible amount in the chart.

Pre-Authorization
For any course of treatment exceeding $350, you should submit a request for pre-authorization. This procedure ensures appropriate treatment and financial responsibility. If you use a participating dentist, your dentist will submit the authorization form for you. If your dentist is not part of the network, you will have to submit a pre-authorization form to your dentist for completion and then forward it to us for approval.

Your First Visit
Because preventive dental care is so important, your National Dental PPO Plan provides benefits for X-rays and teeth cleaning. 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.

Conditions of Service
Services must be provided by a licensed dentist and must be for treatment of dental disease, defect or injury, and are subject to any Exclusions and Limitations or Benefit Maximums specified under the plan.

Benefit Maximums
Dental benefits are limited to a maximum payment for expenses incurred by each insured person during a calendar year. Please refer to the amount on the chart.

Continuing Coverage
As required by federal law, insured persons may continue their coverage under the Group Policy, subject to the payment of premiums to the group. Certain restrictions and conditions apply to the right to continue coverage and are described in your Certificate. Arrangements must be made with the group for this continued coverage.

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

Filing a Claim
If you choose a National Dental PPO participating dentist, he or she will submit your claims for you. If your provider is not in the network, you must complete and submit your own claim forms.
### Calendar Year Deductible

$50/insured person; maximum of $150/family

### Annual Maximum

$1,500

### Predetermination of Benefits

Charges in excess of $350

### Covered Expense

#### PPO Dentists

Plan payments will be applied to the lesser of the charges billed by the provider or the following:

- The Preferred Provider Organization Plan negotiated rate or fee.

*When using a participating dentist, insured persons are not responsible for the difference between the provider's usual charges and the negotiated amount.*

#### Non-PPO Dentists

The amount calculated by us, as specified in the Certificate, for professional services in the dentist's geographical location.

*When using a non-participating dentist, insured persons are responsible for the difference between the covered amount and actual charges, in addition to any deductible, and copayment amounts.*

### Covered Services

#### Covered Services

<table>
<thead>
<tr>
<th>Per Insured Person Copay</th>
<th>PPO Dentists</th>
<th>Non-PPO Dentists</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostics</strong> (exams)</td>
<td>No copay</td>
<td>No copay</td>
</tr>
<tr>
<td><strong>Preventive</strong> (teeth cleanings)</td>
<td>No copay</td>
<td>No copay</td>
</tr>
<tr>
<td><strong>Restorative</strong> (fillings, sealants and space maintainers)</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Endodontics</strong> (root canal therapy)</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Periodontics</strong> (gum surgery)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Oral Surgery</strong> (extractions)</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Prosthodontics</strong> (dentures, crowns, bridges)</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

This Summary of Benefits is a brief review of benefits. Once enrolled, insured persons will receive the Certificate, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.
Fixed bridges, removable cast partials, cast crowns, or any other prosthetic appliances which have been lost or stolen if replacement occurs within five years of the original placement.

Prosthetics (patients under 16 years old). Fixed bridges, removable cast partials, cast crowns, with or without veneers and inlays for persons under 16 years of age.

Implants. Implants (materials implanted into or on bone or soft tissue) or the removal of implants. However, if implants are provided in connection with a covered prosthetic appliance, we will allow the cost of the standard complete or partial denture, or a bridge, toward the cost of the implants and the prosthetic appliances.

Malignancies and Neoplasms. Services for treatment of malignancies and neoplasms.

X-rays. More than one set of full-mouth X-rays or its equivalent in a three-year period. Periodical X-rays submitted individually will be combined and paid up to the amount of a full-mouth series.

Bite Wing X-rays. Bite-wing X-rays in excess of two series for standard or 8 films for vertical bite wings twice in any 12-month period.

Cosmetic Dentistry. Any services performed for cosmetic purposes, unless they are for correction of functional disorders or as a result of an accidental injury occurring while the insured person was covered for dental benefits under this plan.

Congenital or Developmental Malformation. Services to correct a congenital or developmental malformation including, but not limited to, cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (discoloration of the teeth) and anodontia (congenitally missing teeth).

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

Prophylaxis or Periodontal Prophylaxis. Prophylaxis or periodontal prophylaxis procedures are limited to two treatments per calendar year. Periodontal prophylaxis must be preceded by active periodontal treatment, such as scaling and root planing or osseous (gum) surgery.

Sealants. Sealants are limited to children under 16 years of age for permanent unrestored molars. Treatment is limited to once every 36 months per tooth.

Prescription Drugs and Medications. Any prescribed drugs, pre-medication or analgesia.


Space Maintainers. Use of space maintainers in excess of one treatment per lifetime, which includes one adjustment within six month of placement.

Periodontal Surgery. Periodontal surgery exceeding one time per quadrant in a 36-month period.

Root Canal Therapy. Root canal therapy in excess of one treatment per tooth for initial treatment and one retreatment per tooth.

Periodontal Scaling. Periodontal scaling exceeding one time per quadrant in a 24 month period.

Oral Surgery. Extraction of third molars (wisdom teeth) if the patient is under the age of 16.

Teeth Lost Prior to this Coverage. Teeth lost prior to coverage under this plan are not eligible for prosthetic replacement unless the prosthetic replacement replaces one or more eligible natural teeth lost during the term of this coverage.

Restorations. Restorations exceeding one every 12 months per surface per tooth for patients under the age of 19 and one every 36 months per surface per tooth for patients over the age of 19.

Precision Attachments. Precision attachments and the replacement of part of a precision appliance.

Overdentures. Overdentures and related services, including root canal therapy on teeth supporting an overdenture.

Third Molars. The replacement of extracted or missing third molars/wisdom teeth.

Replacement of Existing Restorations. Replacement of existing restorations for any purpose other than restoring active decay.

Harmful Habit Appliances. Fixed and Removable appliances to inhibit thumb-sucking.

Late Entrance Waiting Periods. If the insured person does not enroll within 31 days of eligibility date, the following late entrance waiting periods will apply to services for:

- Preventive and Diagnostic
- Restorative, Periodontics, Endodontics, or Oral Surgery
- Prosthodontics

Third Party Liability. Anthem Blue Cross Life and Health Insurance Company is entitled to reimbursement of benefits paid if the insured person recovers damages from a legally liable third party.

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