Your plan details

In this next section, you'll find more information about your plan.

Anthem
Dental Benefits Program
PO Box 1171
Minneapolis, MN 55440-1171
Phone: 1-877-567-1804
anthem.com/ca/mydental

07/01/2015

Anthem. BlueCross

Welcome to Anthem Dental Complete!

Dear Member:

As of 07/012015, your new dental plan will now be Anthem Dental Complete.

It covers checkups to help prevent or catch concerns early
Healthy teeth make for a super smile. And we want to help keep you smiling. So your new plan has great dental benefits to help keep your teeth healthy. It includes coverage for things like regular checkups, cleanings and checking for mouth or gum problems like oral disease.

We want to help you get you the right care for any dental concerns that could affect your overall health. That's why we have a lot more benefits. So check your Certificate of Coverage or login to your account at anthem.com/ca/mydental for what's covered.

Be sure your dental provider is in the network
To start out, call your dentist or other dental provider. Ask if he or she is part of the Anthem Dental Complete network. If not, you may want to think about switching so you can enjoy all the benefits covered under your plan and keep your costs down. To find an in-network dentist, just search online:

- Go to anthem.com/ca/mydental.
- Click on **Find Dental Providers.**
- Then choose your plan, Dental Complete.

Make an appointment for a checkup
It'll be the first one covered by your new plan. In the coming weeks, you'll get a new dental ID card from us. Show your new dental ID card to your dentist at your first visit. Ask your provider to record the new Group Number, new Member ID, new claims address and new customer service phone number in their files. The dentist office will need this information to file your claim.

Always double-check your coverage before any visit
If you are scheduled to see your dentist after <<date>>, the date that your new plan goes into effect, be sure to confirm that the service is covered under the new plan. Just call the dental customer service phone number on your ID card. Or, ask your dentist to submit a pre-treatment estimate.

If you have any questions about this letter or your plan, please feel free to call 877-567-1804, Monday through Friday, 5 a.m. to 6 p.m. Pacific.

Wishing you the best of health,

Dental Case Implementation Team
Anthem

Anthem BlueCross

WORK-IN-PROGRESS EXPLANATION

Non-Orthodontic Services Work-In-Progress

For all services other than orthodontics, (e.g., root canals, crowns, bridges, dentures) that started prior to the subscriber's effective date under the Prime and Complete dental plan, payment of the claim is based on the service completion date.

The Prime and Complete dental plan will honor the prior carrier's pre-estimate, but only in determining coverage. Pricing and network status are not guaranteed and will be based on the provider's participating status with Prime and Complete.

The provider/subscriber should attach the prior plan's pre-estimate to the claim when submitting to Prime and Complete dental for consideration.

Orthodontic Work-In-Progress

If a covered eligible member (adult or dependent child) is in the midst of active orthodontic treatment (bands have been placed), the provider needs to supply Anthem dental with a copy of the original claim that must include the following information:

1) Treatment type (procedure number)
2) Total fee for treatment
3) Number of months treatment will take place
4) Provider signature

The amount of the benefit that will be paid will be pro-rated based on the number of months of active treatment remaining following the effective date of the member (minus any amount paid by the prior carrier if history is loaded.)

Example:

Treatment Plan Length and Cost:	24 months for $5,200
Remaining Months of Treatment:	10 months
Monthly Treatment Cost:	$5,200/24 months = $216.66 monthly
Ineligible Monthly Cost:	14 months x $216.66 = $3,033.24
Eligible Treatment Cost:	$5,200 - $3,033.24 = $2,166.76
Amount Paid by Anthem:	$2,166.76 x 50% = $1,083.38*

** The total amount paid will be limited to the total Lifetime Orthodontic Maximum minus any prior carrier history, if loaded.*

Standard Ortho Payment Schedule

- $500-$1,500 Lifetime Orthodontic Maximum = 2 Equal Payments (banding & 6 months after banding)
- $1,500+ Lifetime Orthodontic Maximum = 3 Equal Payments (banding, 6 months after banding, 12 months after banding)

Anthem Dental Claims Mailing Address

Anthem
PO Box 1115
Minneapolis, MN 55440-1115

Anthem BlueCross

How to Guide:
To Find a Provider

STEP 1:	Go to **www.anthem.com/ca/mydental**
STEP 2:	**Click on "Find Dental Providers"** (middle of page)
STEP 3:	**Click on either Anthem Dental Prime or Anthem Dental Complete** (the plan name is located on your member ID card)
STEP 4:	**Select a Specialty (if needed); Click "Next"**
STEP 5:	**Enter your criteria for the provider search and click on "View Results"**
STEP 6:	**To lookup a provider by name, click on "Lookup by Name" at the top of the page**
STEP 7:	**On the Search Results page, you can: Download Results; Print a PDF of your results; and Start a new search**

CA_01_2012

Your Summary of Benefits
Plan D
Anthem Dental Complete

Anthem BlueCross

WELCOME TO YOUR DENTAL PLAN!
This benefit summary outlines how your dental plan works and provides you with a quick reference of your dental plan benefits. For complete coverage details, please refer to your employee benefits booklet.

Dental coverage you can count on
Your Anthem dental plan lets you visit any licensed dentist or specialist you want – with costs that are normally lower when you choose one within our large network.

Savings beyond your dental plan benefits – you get more for your money.
You pay our negotiated rate for covered services from in-network dentists even if you exceed your annual benefit maximum.

YOUR DENTAL PLAN AT A GLANCE	In-Network	Out-of-Network
Annual Benefit Maximum – (Calendar Year) • Per insured person **Annual Maximum Carryover**	 **$2,000** **No**	**$2,000** **No**
Orthodontic Lifetime Benefit Maximum • Per eligible person	**$1,500**	**$1,500**
Annual Deductible – (Calendar Year) • Per insured person • Family maximum	**$0** **3x single member deductible**	**$0** **3x single member deductible**
Deductible Waived for Diagnostic/Preventive Services	**Yes**	**Yes**
Out-of-Network Reimbursement	**80th percentile**	

Dental Services	In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period
Diagnostic and Preventive Services • Periodic oral exam • Teeth cleaning (prophylaxis) • Bitewing X-rays (once in 12 mos. for all ages) • Intraoral X-rays	**100% coinsurance**	**100% coinsurance**	**No waiting period**
Basic Services • Amalgam (silver-colored) Filling • Front composite (tooth-colored) Filling • Back Composite Filling, alternated to amalgam allowance • Simple Extractions	**90% coinsurance**	**80% coinsurance**	**No waiting period**
Endodontics • Root canal	**90% coinsurance**	**80% coinsurance**	**No waiting period**
Periodontics • Scaling and root planing	**90% coinsurance**	**80% coinsurance**	**No waiting period**
Oral Surgery • Surgical Extractions	**90% coinsurance**	**80% coinsurance**	**No waiting period**
Major Services • Crowns	**60% coinsurance**	**50% coinsurance**	**No waiting period**
Prosthodontics • Dentures • Bridges • Dental Implants	**60% coinsurance**	**50% coinsurance**	**No waiting period**
Prosthetic Repairs/Adjustments	**90% coinsurance**	**80% coinsurance**	**No waiting period**
Orthodontic Services • Adults and dependent children	**50% coinsurance**	**50% coinsurance**	**No waiting period**
Dental Accident Benefit*	**100% coinsurance**	**100% coinsurance**	**No waiting period**

*Applies to annual benefit maximum
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 your employee benefits booklet. **In the event of a discrepancy between the information in this summary and the employee benefits booklet, the booklet will prevail. ABC_PCLG_ASO-Custom**

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 dentists while traveling or working nearly anywhere in the world.

** The International Emergency Dental Program is managed by DeCare Dental, which is 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.decaredental.com/internationalDentalProgram.do.

Finding a dentist is easy.

To select a dentist by name or location, do one of the following:

- Go to anthem.com/ca/mydental
- Call Anthem dental customer service at the toll-free number listed on the back of your ID card.

TO CONTACT US:

Call	Write
Refer to the toll-free number indicated on the back of your plan ID card to speak with a U.S.-based customer service representative during normal business hours. Calling after hours? We may still be able to assist you with our interactive voice-response system.	Refer to the back of your plan ID card for the address.

Limitations & Exclusions

Limitations – Below is a partial listing of dental plan limitations when these services are covered under your plan. Please see your employee benefits booklet for a full list.

Diagnostic and Preventive Services

Oral evaluations (exam) Limited to two per Calendar Year

Teeth cleaning (prophylaxis) Limited to three per Calendar Year

Intraoral X-rays, single film Limited to four films per 12-month period

Complete series X-rays (panoramic or full-mouth) Limited to once every three years
Topical fluoride application Limited to once every 12 months for members through age 18

Sealants Limited to first and second molars once every 60 months per tooth for members through age 13; sealants may be covered under Diagnostic and Preventive or Basic Services.

Basic and/or Major Services***

Fillings

Space Maintainers Limited to extracted primary posterior teeth once per lifetime per tooth for members through age 18; space maintainers may be covered under Diagnostic and Preventive or Basic Services.

Crowns Limited to once per tooth in a five-year period

Fixed or removable prosthodontics – dentures, partials, bridges, tooth implants
Covered once in any five-year period; benefits are provided for the replacement of an existing bridge, denture or partial for members age 16 or older if the appliance is five years old or older and cannot be made serviceable.

Root canal therapy Limited to once per24 months per tooth; coverage is for permanent teeth only.

Periodontal surgery Limited to one complex service per single tooth or quadrant in any 36 months, and only if the pocket depth of the tooth is five millimeters or greater

Periodontal scaling and root planing Limited to once per quadrant in 24 months, when the tooth pocket has a depth of four millimeters or greater

Brush biopsy (Not covered)

***Waiting periods** for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan. There may be a waiting period of up to 24 months for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

ADDITIONAL LIMITATION FOR ORTHODONTIC SERVICES – ***if Orthodontia is included as a benefit of your dental plan***
Orthodontia Limited to one course of treatment per member per lifetime

Exclusions – Below is a partial listing of noncovered services under your dental plan. Please see your employee benefits booklet for a full list.

Services provided before or after the term of this coverage Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate

Orthodontics (unless included as part of your dental plan benefits) Orthodontic braces, appliances and all related services

Cosmetic dentistry Services provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist

Drugs and medications Intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care

Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

Extractions Surgical removal of third molars (wisdom teeth) that do not exhibit symptoms or impact the oral health of the member

The in-network dental providers mentioned in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of Anthem Blue Cross Life and Health Insurance Company.

Choice of dentists
While your dental plan lets you choose any dentist, you may end up paying more for a service if you visit an out-of-network dentist.

Here's why:
In-network dentists have agreed to payment rates for various services and cannot charge you more. On the other hand, out-of-network dentists don't have a contract with us and are able to bill you for the difference between the total amount we allow to be paid for a service – called the "maximum allowed cost" – and the amount they usually charge for a service. When they bill you for this difference, it's called "balance billing."

How Anthem dental decides on maximum allowed costs
For services from an out-of-network dentist, the maximum allowed cost is determined in one of the following ways:

- Out-of-network dental fee schedule/rate developed by Anthem, which may be updated based on such things as reimbursement amounts accepted by dentists contracted with our dental plans, or other industry cost and usage data
- Information provided by a third-party vendor that shows comparable costs for dental services
- In-network dentist fee schedule

Here's an example of higher costs for out-of-network dental services
This is an example only. Your experience may be different, depending on your insurance plan, the services you receive and the dentist who provides the services.

Say Ted's dental plan allows him 50% coinsurance for either in- or out-of-network services... Ted chooses to get a crown from an out-of-network dentist who charges $1,200 for the service and bills Anthem for that amount. If Anthem's maximum allowed cost for this dental service is $800, this means there will be a $400 difference. The out-of-network dentist can "balance bill" Ted for that amount.

Ted will also need to pay $400 coinsurance. Therefore, the total he will pay the out-of-network dentist is $800. Here's the math:

- Dentist's charge: $1,200
- Anthem's maximum allowed cost: $800
- Anthem pays 50%: $400
- Ted pays 50% (coinsurance): **$400**
- Balance Ted owes the provider: $1,200 - $800 = **$400**
- Ted's total cost: **$400** coinsurance + **$400** provider balance = **$800**

In the example, if Ted had gone to an in-network dentist, his cost would be only $400 for the coinsurance because he would not have been "balance billed" the $400 difference.

How we protect our members

As a member, you have the right to expect the privacy of your personal health information to be protected, consistent with state and federal laws and our policies. And you also have certain rights and responsibilities when receiving your health care.

To learn more about how we protect your privacy, your rights and responsibilities when receiving health care and your rights under the Women's Health and Cancer Rights Act, go to www.anthem.com/ca/memberrights.

How we help manage your care

To decide if we'll cover a treatment, procedure or hospital stay, we use a process called Utilization Management (UM). UM is a program that lets us make sure you're getting the right care at the right time. Licensed health care professionals review information your doctor has sent us to see if the requested care is medically needed. These reviews can be done before, during or after a member's treatment. UM also helps us decide if the services will be covered by your health plan.

We also use case managers. They're licensed health care professionals who work with you and your doctor to help you learn about and manage your health conditions. They also help you better understand your health benefits.

To learn more about how we help manage your care, visit www.anthem.com/ca/memberrights.

Special Enrollment Rights

There are certain situations when you can enroll in a plan outside the open enrollment period. Open enrollment usually happens only once a year. That's the time you can enroll in a plan or make changes to it. If you choose not to enroll during open enrollment, there are special cases when you're allowed to enroll yourself and your dependents. Special enrollment is allowed:

- ***If you had another health plan that was canceled.*** If you, your dependents or your spouse are no longer eligible for other coverage (or if the employer stops contributing to your health plan), you may be able to enroll with us. You must enroll within 31 days after the other coverage ends (or after the employer stops paying for it).
  - For example: You and your family are enrolled through your spouse's coverage at work. Your spouse's employer stops paying for health coverage. In this case, you and your spouse, as well as other dependents, may be able to enroll in a plan.
- ***If you have a new dependent.*** This could mean a life event like marriage, birth, adoption or if you have custody of a minor and an adoption is pending. You must enroll within 31 days after the event. For example: If you got married, your new spouse and any new children may be able to enroll in a plan.
- ***If your eligibility for Medicaid or SCHIP changes.*** You have a special period of 60 days to enroll after:
  - You (or your eligible dependents) lose Medicaid or CHIP coverage because you're no longer eligible.
  - You (or eligible dependents) become eligible to get help from Medicaid or SCHIP for paying part of the cost.

Notes