

Your Summary of Dental Benefits for Buy-up Plan Central Garden & Pet Anthem Dental Complete

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	\$1,500	
Annual Maximum Carryover	No	No
Orthodontic Lifetime Benefit Maximum • Per eligible person	\$1,500	
Annual Deductible – (Calendar Year) • Per insured person • Family maximum	\$25 3x single member deductible	
Deductible Waived for Diagnostic/Preventive Services	Yes	Yes
Out-of-Network Reimbursement	90th 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 (twice 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, covered as composite • Simple Extractions	80% coinsurance	80% coinsurance	No waiting period
Endodontics • Root canal	80% coinsurance	80% coinsurance	No waiting period
Periodontics • Scaling and root planing	70% coinsurance	70% coinsurance	No waiting period
Oral Surgery • Surgical Extractions	80% coinsurance	80% coinsurance	No waiting period
Major Services • Crowns	70% coinsurance	70% coinsurance	No waiting period
Prosthodontics • Dentures • Bridges • Dental Implants (covered)	70% coinsurance	70% coinsurance	No waiting period
Prosthetic Repairs/Adjustments	70% coinsurance	70% coinsurance	No waiting period
Orthodontic Services • Adults and dependent children*	50% coinsurance	50% coinsurance	No waiting period

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.

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	
<p>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.</p> <p><u>Diagnostic and Preventive Services</u> Oral evaluations (exam) Limited to two per Calendar Year Teeth cleaning (prophylaxis) Limited to two 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 two per calendar year for all ages Sealants Limited to first and second molars once every 36 months per tooth for members through age 16; sealants covered under Diagnostic and Preventive.</p> <p><u>Basic and/or Major Services***</u> Fillings Limited to once per surface per tooth in any 24 months Space Maintainers Limited to extracted primary posterior teeth once per lifetime; space maintainers covered under Diagnostic and Preventive. 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. Implants covered once in any seven-year period. Root canal therapy Limited to once in any five-year period; 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)</p>	<p>Exclusions – Below is a partial listing of noncovered services under your dental plan. Please see your employee benefits booklet for a full list.</p> <p>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</p> <p>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</p> <p>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.</p>

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.