Anthem BlueCross

Ready to choose *your benefits?*

We can point you in the right direction.

Medical/Dental/Vision
Good Nite Inn
Effective August 1, 2018

This guide is for information purposes only. You must enroll in a plan for your benefits to start.

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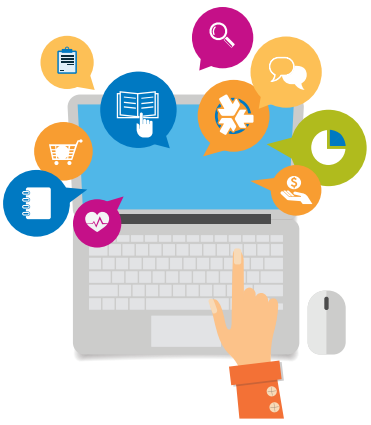
Let's take a look

We know picking a plan is a big deal, so this guide makes it easier for you to understand your benefit options. We'll explain how the plans work and give you other important details. That way you can enroll with confidence!

In this guide, you'll find:

- Dental and vision benefits

Pay a visit to anthem.com/ca to get an idea of what you can do once you're a member. Find a doctor, estimate care costs, sign up to get emails instead of mail and much more!



Dental and Vision benefits

When you enroll, you'll probably need to sign up separately for the benefits in this section.

Dental

Dental benefits not only protect your teeth, but can support overall health, too. Some conditions like heart disease, for example, can have warning signs in the mouth and gums. Our dental plan gives you all the benefits you need for a healthy mouth and more.

Vision

With Blue View Vision℠, you have access to over 36,000 doctors at over 27,000 locations across the country, including convenient retail stores like LensCrafters® Sears Optical℠, Target Optical® or JCPenney® Optical. You also can order glasses and contacts online through Glasses.com **(glasses.com),** ContactsDirect (**ContactsDirect.com**) or 1-800-CONTACTS (**1800contacts.com**).

Your Anthem ID card gives you access to quality care from quality doctors.

Your plan details

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

Your summary of benefits

Anthem BlueCross

Anthem Blue Cross

Your Plan: Value Deductible HMO $1,500 25/40/25% (Essential Formulary $5/$20/$40/$75/30% $250 Deductible)

Your Network: California Care HMO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Anthem Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA); except OB/GYN services received within the member's medical group/IPA, and services for mental and nervous disorders and substance abuse. Benefits are subject to all terms, conditions, limitations, and exclusions of the EOC.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$1,500 per member	$0
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$3,000 single / $6,000 family	$0
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	Not covered
Doctor Home and Office Services		
Primary care visit to treat an injury or illness	$25 copay per visit	Not covered
Specialist care visit	$40 copay per visit	Not covered
Prenatal and Post-natal Care	$25 copay per visit	Not covered
Other practitioner visits: Retail health clinic	Not covered	Not covered

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
On-line Visit	Not covered	Not covered
Chiropractor services *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Chiropractor visits count towards your physical and occupational therapy limit.*	$25 copay per visit	Not covered
Acupuncture	$25 copay per visit	Not covered
Other services in an office:		
Allergy testing	$25 copay per visit	Not covered
Chemo/radiation therapy	$40 copay per visit	Not covered
Hemodialysis	$40 copay per visit	Not covered
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	30% coinsurance up to $150 per visit	Not covered
Diagnostic Services		
Lab:		
Office	No charge	Not covered
Freestanding Lab	No charge	Not covered
Outpatient Hospital *Deductible applies.*	25% coinsurance	Not covered
X-ray:		
Office	No charge	Not covered
Freestanding Radiology Center	No charge	Not covered
Outpatient Hospital *Deductible applies.*	25% coinsurance	Not covered
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	$100 copay per test	Not covered

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Costs may vary by site of service.		
Freestanding Radiology Center *Costs may vary by site of service.*	$100 copay per test	Not covered
Outpatient Hospital *Deductible applies. Costs may vary by site of service.*	25% coinsurance	Not covered
Emergency and Urgent Care		
Emergency room facility services *This is for the hospital/facility charge only. The ER physician charge may be separate. Copay waived if admitted. Deductible applies.*	$150 copay and then 25% coinsurance	Covered as In-Network
Emergency room doctor and other services	No charge	Covered as In-Network
Ambulance (air and ground)	$100 copay per trip for ground and air	Covered as In-Network
Urgent Care (office setting) *Copay waived if admitted. Costs may vary by site of service.*	$25 copay per visit	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	$25 copay per visit medical deductible does not apply	Not covered
Facility visit:		
Facility fees	No charge Medical deductible does not apply	Not covered
Outpatient Surgery		
Facility fees:		
Hospital *Deductible applies.*	25% coinsurance	Not covered
Freestanding Surgical Center *Deductible applies.*	25% coinsurance	Not covered
Doctor and other services	No charge	Not covered
Hospital Stay (all inpatient stays including maternity, mental /		

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
behavioral health, and substance abuse)		
Facility fees (for example, room & board) *Deductible applies.*	25% coinsurance	Not covered
Doctor and other services	No charge	Not covered
Recovery & Rehabilitation		
Home health care *Coverage for In-Network Provider is limited to 100 visit limit per benefit period.*	$25 copay per visit	Not covered
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Costs may vary by site of service. Chiropractor visits count towards your physical and occupational therapy limit.*	$25 copay per visit	Not covered
Outpatient hospital *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Deductible applies.*	25% coinsurance	Not covered
Habilitation services *Habilitation visits count towards your rehabilitation limit. Deductible applies.*	25% coinsurance	Not covered
Cardiac rehabilitation		
Office	$25 copay per visit	Not covered
Outpatient hospital *Deductible applies.*	25% coinsurance	Not covered
Skilled nursing care (in a facility) *Coverage for In-Network Provider is limited to 100 day limit per benefit period. Deductible applies.*	25% coinsurance	Not covered
Hospice	No charge *Medical deductible does*	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	not apply.	
Durable Medical Equipment	50% coinsurance	Not covered
Prosthetic Devices	No charge	Not covered

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	$250 single / $750 family	$250 single / $750 family
Pharmacy Out of Pocket	Combined with medical out of pocket	Combined with medical out of pocket
Prescription Drug Coverage *This plan uses an Essential formulary List. Drugs not on the list are not covered.*		
Tier1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) Prescription Drug deductible does not apply. This plan uses an Essential Formulary drug list. You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Member pays the retail pharmacy copay plus 50% for out of network.*	Tier1a - Typically Lower Cost Generic $5 copay per prescription (retail only) and $12.50 copay per prescription (home delivery only) Tier1b - Typically Generic $20 copay per prescription (retail only) and $50 copay per prescription (home delivery only).	Tier 1a 50% coinsurance up to $250 per prescription (retail only) Tier 1b 50% coinsurance up to $250 per prescription (retail only).
Tier2 - Typically Preferred / Brand *Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) Member pays the retail pharmacy copay plus 50% for out of network.*	Tier 2 - Typically Preferred Brand & non-preferred generic drugs $40 copay per prescription (retail only) and $120 copay per prescription (home delivery only).	Tier 2 - 50% coinsurance up to $250 per prescription (retail only).
Tier3 - Typically Non-Preferred / Specialty Drugs *Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply*	Tier 3 - Typically Non-Preferred	Tier 3 - 50% coinsurance up to

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
(home delivery program) Member pays the retail pharmacy copay plus 50% for out of network.	Brand and generic drugs $75 copay per prescription (retail only) and $225 copay per prescription (home delivery only.	$250 per prescription (retail only).
Tier4 - Typically Specialty Drugs *Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program. Covers up to a 30 day supply (retail pharmacy and home delivery program) . Member pays the retail pharmacy copay plus 50% for out of network.*	Tier 4 - Typically Specialty (brand and generic) 30% coinsurance up to $250 per prescription (retail and home delivery).	Tier 4 - 50% coinsurance up to $250 per prescription (retail only).

Your summary of benefits

Notes:

- This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).
- In addition to the benefits described in this summary, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.
- Your plan requires a selection of a Primary Care Physician. Your plan requires a referral from your Primary Care Physician for select covered services.
- The medical deductible applies to certain services such as: services in an inpatient/outpatient facility, emergency room. A separate pharmacy deductible applies to pharmacy benefits for applicable plans.
- Preventive Care Services includes physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration.
- For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Respite Care limited to 5 consecutive days per admission.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- Infertility services are not included in the out of pocket amount.
- Coordination of Benefits: The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverage do not exceed 100% of the covered expense
- When using non-network pharmacy; members are responsible for in-network pharmacy copay plus 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.
- Supply limits for certain drugs may be different, go to Anthem website or call customer service.
- Certain drugs require pre-authorization approval to obtain coverage.

- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=CA_LG_HMO
- For additional information on this plan, please visit sbc.anthem.com to obtain a Summary of Benefit Coverage.

Your summary of benefits

Anthem BlueCross

Anthem Blue Cross Life and Health Insurance Company

Your Plan: Solution PPO 2500/25/20 (Essential Formulary $5/$20/$40/$60/30%)

Your Network: Prudent Buyer PPO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$2,500 single / $5,000 family	$7,500 single / $15,000 family
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$6,350 single / $12,700 family	$19,050 single / $38,100 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	40% coinsurance
Doctor Home and Office Services		
Primary care visit to treat an injury or illness *Deductible does not apply to In-Network providers.*	$25 copay per visit	40% coinsurance
Specialist care visit *Deductible does not apply to In-Network providers.*	$25 copay per visit	40% coinsurance
Prenatal and Post-natal Care *Deductible does not apply to In-Network providers.*	$25 copay per visit	40% coinsurance
Other practitioner visits: Retail health clinic *Deductible does not apply to In-Network providers.* On-line Visit *Deductible does not apply to In-Network providers.*	$25 copay per visit $10 copay per visit	40% coinsurance 40% coinsurance

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Chiropractor services *Coverage for In-Network Provider and Non-Network Provider combined is limited to 30 visit limit per benefit period. Deductible does not apply to In-Network providers.*	$25 copay per visit	40% coinsurance
Acupuncture *Coverage for In-Network Provider and Non-Network Provider combined is limited to 20 visit limit per benefit period. Deductible does not apply to In-Network providers.*	$25 copay per visit	40% coinsurance
Other services in an office:		
Allergy testing	20% coinsurance	40% coinsurance
Chemo/radiation therapy	20% coinsurance	40% coinsurance
Hemodialysis	20% coinsurance	40% coinsurance
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	20% coinsurance	40% coinsurance
Diagnostic Services		
Lab:		
Office	20% coinsurance	40% coinsurance
Freestanding Lab	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
X-ray:		
Office	20% coinsurance	40% coinsurance
Freestanding Radiology Center	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance	40% coinsurance
Freestanding Radiology Center	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
Emergency and Urgent Care		

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency room facility services *This is for the hospital/facility charge only. The ER physician charge may be separate. Copay waived if admitted.*	$150 copay per admission and then 20% coinsurance	Covered as In-Network
Emergency room doctor and other services	20% coinsurance	Covered as In-Network
Ambulance (air and ground)	20% coinsurance	Covered as In-Network
Urgent Care (office setting) *Deductible does not apply to In-Network providers. Costs may vary by site of service.*	$25 copay per visit	40% coinsurance
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	$25 copay per visit	40% coinsurance
Facility visit:		
Facility fees	20% coinsurance	40% coinsurance
Outpatient Surgery		
Facility fees:		
Hospital	20% coinsurance	40% coinsurance
Freestanding Surgical Center	20% coinsurance	40% coinsurance
Doctor and other services	20% coinsurance	40% coinsurance
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board) *Co-pay $500 if you do not receive preauthorization. Apply to non-emergency admission.*	20% coinsurance	40% coinsurance
Doctor and other services	20% coinsurance	40% coinsurance
Recovery & Rehabilitation		
Home health care *Coverage for In-Network Provider and Non-Network Provider combined is*	20% coinsurance	40% coinsurance

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
limited to 100 day limit per benefit period.		
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Costs may vary by site of service.*	20% coinsurance	40% coinsurance
Outpatient hospital	20% coinsurance	40% coinsurance
Habilitation services	20% coinsurance	40% coinsurance
Cardiac rehabilitation		
Office	20% coinsurance	40% coinsurance
Outpatient hospital	20% coinsurance	40% coinsurance
Skilled nursing care (in a facility) *Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 day limit per benefit period.*	20% coinsurance	40% coinsurance
Hospice *Deductible does not apply to In-Network providers.*	No charge	40% coinsurance
Durable Medical Equipment	50% coinsurance	50% coinsurance
Prosthetic Devices	20% coinsurance	40% coinsurance

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	$0	$0
Pharmacy Out of Pocket	Combined with medical out of pocket	Combined with medical out of pocket
Prescription Drug Coverage *This plan uses an Essential formulary List. Drugs not on the list are not covered.*		
Tier1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) This plan uses an Essential Formulary drug list. You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Member pays the retail pharmacy copay plus 50% for out of network.*	Tier1a - Typically Lower Cost Generic $5 copay per prescription (retail only) and $12.50 copay per prescription (home delivery only) Tier1b - Typically Generic $20 copay per prescription (retail only) and $50 copay per prescription (home delivery only).	Tier 1a 50% coinsurance up to $250 per prescription (retail only) Tier 1b 50% coinsurance up to $250 per prescription (retail only).
Tier2 - Typically Preferred / Brand *Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) Member pays the retail pharmacy copay plus 50% for out of network.*	Tier 2 - Typically Preferred Brand & non-preferred generic drugs $40 copay per prescription (retail only) and $120 copay per prescription (home delivery only).	Tier 2 - 50% coinsurance up to $250 per prescription (retail only).
Tier3 - Typically Non-Preferred / Specialty Drugs *Certain drugs require preauthorization approval to obtain coverage. Covers up to*	Tier 3 - Typically Non-Preferred	Tier 3 -50% coinsurance up to

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program). Member pays the retail pharmacy copay plus 50% for out of network.	Brand and generic drugs $60 copay per prescription (retail only) and $180 copay per prescription (home delivery only.	$250 per prescription (retail only).
Tier4 - Typically Specialty Drugs *Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program. Covers up to a 30 day supply (retail pharmacy and home delivery program) Member pays the retail pharmacy copay plus 50% for out of network.*	Tier 4 - Typically Specialty (brand and generic) 30% coinsurance up to $250 per prescription (retail and home delivery).	Tier 4 - 50% coinsurance up to $250 per prescription (retail only).

Your summary of benefits

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- In addition to the benefits described in this summary, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.
- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- Annual Out-of-Pocket Maximums includes deductible, copays, coinsurance and prescription drug.
- In network and out of network deductible and out of pocket maximum are exclusive of each other.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- Preventive Care Services includes physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration.
- For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- If your plan includes out of network benefit and you use a non-network provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.
- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.
- Certain types of physicians may not be represented in the PPO network in the state where the member receives services. If such physician is not available in the service area, the member's copay is the same as for PPO (with and without pre-notification, if applicable). Member is responsible for applicable copays, deductibles and charges which exceed covered expense.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.

Your summary of benefits

- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Transplants covered only when performed at Centers of Medical Excellence or Blue Distinction Centers.
- Bariatric Surgery covered only when performed at Blue Distinction Center for Specialty Care for Bariatric Surgery.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Respite Care limited to 5 consecutive days per admission.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- Coordination of Benefits: The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverage do not exceed 100% of the covered expense
- When using non-network pharmacy; members are responsible for in-network pharmacy copay plus 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.
- Supply limits for certain drugs may be different, go to Anthem website or call customer service.
- Certain drugs require pre-authorization approval to obtain coverage.
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=CA_LG_PPO
- For additional information on this plan, please visit sbc.anthem.com to obtain a Summary of Benefit Coverage.

Your Summary of Benefits
Dental Net® Dental HMO Plan 2000A

WELCOME TO YOUR DENTAL PLAN! This benefit summary outlines the basic components of Anthem's Dental Net DHMO Plans – providing you with a quick reference of your dental benefits. For complete coverage details, please refer to the Combined Evidence of Coverage and Disclosure Form.

Dental coverage you can count on

With our Dental Net DHMO plans, there are no annual benefit maximums[1] or deductibles, and there are set copayments for services you receive. You choose a dental office and primary dentist from our directory of participating dentists. The dentist you select will provide all routine dental services and arrange for any specialty care you may need. After enrollment, you will receive a member ID card listing your selected dental office and phone number. You may transfer from one participating dentist to another if you choose. To do so, just call or write us by the 15th of the month before the month you wish to transfer. If approved, your transfer request will be effective on the first of the month after we receive it.

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, English-speaking dentists while traveling or working nearly anywhere in the world.

+The International Emergency Dental Program is managed by DeCare Dental, 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.decare.com/internationalDentalProgram.do.

YOUR DENTAL NET PLAN AT A GLANCE

The chart below shows nearly 300 services and corresponding Current Dental Terminology (CDT) codes † covered by our Dental Net plans.

Annual Benefit Maximum: No annual maximum	**Annual Deductible:** No deductible

CDT Code	Benefit	Copay
Diagnostic Services		
D0120	Periodic oral evaluation – established patient	$0
D0140	Limited oral evaluation – problem focused	$0
D0150	Comprehensive oral evaluation – new or established patient	$0
D0160	Detailed and extensive oral evaluation – problem focused, by report	$0
D0170	Re-evaluation – limited, problem focused (established patient; not postoperative visit)	$0
D0180	Comprehensive periodontal evaluation – new or established patient	$0
D0210	Intraoral X-rays – complete series of radiographic images	$0
D0220	Intraoral X-rays – periapical, first radiographic image	$0
D0230	Intraoral X-rays – periapical, each additional radiographic image	$0
D0240	Intraoral X-rays – occlusal radiographic image	$0
D0250	Extraoral X-rays – first radiographic image	$0
D0260	Extraoral X-rays – each add'l radiographic image	$0
D0270	Bitewing X-rays – single radiographic image	$0
D0272	Bitewing X-rays – two radiographic images	$0
D0273	Bitewing X-rays – three radiographic images	$0
D0274	Bitewing X-rays – four radiographic images	$0
D0277	Vert. bitewings – seven to eight radiographic images	$0
D0330	Panoramic radiographic image	$0
D0350	Oral/facial photographic images	$0
D0415	Collection of microorganisms for culture and sensitivity	$0
D0425	Caries susceptibility tests	$0
D0431	Adjunctive prediagnostic test that aids in detection of mucosal abnormalities, including premalignant and malignant lesions; not to include cytology or biopsy procedures	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
Preventive Services		
D1110	Teeth cleaning (prophylaxis) – adult, two per calendar year	$0
D1120	Teeth cleaning (prophylaxis) – child, two per calendar year	$0

CDT Code	Benefit	Copay
D1206	Topical application of fluoride varnish	$0
D1208	Topical application of fluoride (formerly CDT Codes D1203 and D1204)	$0
D1310	Nutritional counseling for control of dental disease	$0
D1320	Tobacco counseling for the control and prevention of oral disease	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant, per tooth, through age 15	$7
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	$10
D1510	Space maintainer (fixed – unilateral)	$60
D1515	Space maintainer (fixed – bilateral)	$60
D1520	Space maintainer (removable – unilateral)	$70
D1525	Space maintainer (removable – bilateral)	$70
D1550	Re-cementation of space maintainer	$0
D1555	Removal of fixed space maintainer by dentist who did not place appliance	$10
Restorative Services		
D2140	Amalgam (silver colored) filling, one surface, primary or permanent	$0
D2150	Amalgam (silver colored) filling, two surfaces, primary or permanent	$0
D2160	Amalgam (silver colored) filling, three surfaces, primary or permanent	$0
D2161	Amalgam (silver colored) filling, four or more surfaces, primary or permanent	$0
D2330	Resin-based composite (tooth colored) filling, one surface, anterior (front) tooth	$0
D2331	Resin-based composite (tooth colored) filling, two surfaces, anterior (front) tooth	$0
D2332	Resin-based composite (tooth colored) filling, three surfaces, anterior (front) tooth	$0
D2335	Resin-based composite (tooth colored) filling, four or more surfaces or involving incisal angle, anterior (front) tooth	$0
D2390	Resin-based composite (tooth colored) crown, anterior (front) tooth	$30
D2391	Resin-based composite (tooth colored) filling, one surface, posterior (back) tooth	$30
D2392	Resin-based composite (tooth colored) filling, two surfaces, posterior (back) tooth	$45
D2393	Resin-based composite (tooth colored) filling, three surfaces, posterior (back) tooth	$55
D2394	Resin-based composite (tooth colored) filling, four or more surfaces, posterior (back) tooth	$65
D2510	Inlay – metallic, one surface	$100*
D2520	Inlay – metallic, two surfaces	$130*
D2530	Inlay – metallic, three or more surfaces	$130*
D2542	Onlay – metallic, two surfaces	$140*
D2543	Onlay – metallic, three surfaces	$140*
D2544	Onlay – metallic, four or more surfaces	$145*
D2610	Inlay – porcelain/ceramic, one surface	$155*
D2620	Inlay – porcelain/ceramic, two surfaces	$155*
D2630	Inlay – porcelain/ceramic, three or more surfaces	$155*
D2642	Onlay – porcelain/ceramic, two surfaces	$140*
D2643	Onlay – porcelain/ceramic, three surfaces	$145*
D2644	Onlay – porcelain/ceramic, four or more surfaces	$145*
D2650	Inlay – resin-based composite, one surface	$155
D2651	Inlay – resin-based composite, two surfaces	$155
D2652	Inlay – resin-based composite, three+ surfaces	$155

CDT Code	Benefit	Copay
D2662	Onlay – resin-based composite, two surfaces	$140
D2663	Onlay – resin-based composite, three surfaces	$145
D2664	Onlay – resin-based composite, four+ surfaces	$145
D2710	Crown – resin-based composite (indirect)	$150
D2712	Crown – 3/4 resin-based composite (indirect)	$150
D2720	Crown – resin with high noble metal	$150*
D2721	Crown – resin with predominantly base metal	$150
D2722	Crown – resin with noble metal	$150*
D2740	Crown – porcelain/ceramic substrate	$175*
D2750	Crown – porcelain fused to high noble metal	$175*
D2751	Crown – porcelain fused to predominantly base metal	$175*
D2752	Crown – porcelain fused to noble metal	$175*
D2780	Crown – 3/4 cast high noble metal	$150*
D2781	Crown – porcelain/ceramic substrate	$150*
D2782	Crown – 3/4 cast noble metal	$150*
D2783	Crown – 3/4 porcelain/ceramic	$150*
D2790	Crown – full cast high noble metal	$150*
D2791	Crown – full cast predominantly base metal	$150
D2792	Crown – full cast noble metal	$150*
D2794	Crown – titanium	$150*
D2799	Provisional crown – further treatment or completion of diagnosis necessary prior to final impression	$45
D2910	Re-cement inlay, onlay or partial coverage restoration	$10
D2915	Re-cement cast or prefab post and core	$10
D2920	Re-cement crown	$10
D2929	Prefabricated porcelain/ceramic crown, primary tooth	$40*
D2930	Prefabricated stainless steel crown, primary tooth	$35
D2931	Prefabricated stainless steel crown, permanent tooth	$35
D2932	Prefabricated resin crown	$40
D2940	Protective restoration	$0
D2950	Core buildup, including any pins	$25
D2951	Pin retention – per tooth, in addition to restoration	$5
D2952	Post and core in addition to crown, indirectly fabricated	$35
D2953	Each add'l indirectly fabricated post – same tooth	$0
D2954	Prefabricated post and core in addition to crown	$47
D2955	Post removal	$10
D2957	Each additional prefabricated post-same tooth	$0
D2960	Labial veneer, resin laminate/chairside	$240
D2961	Labial veneer, resin laminate/laboratory	$300
D2962	Labial veneer, porcelain laminate/laboratory	$340*
D2970	Temporary crown (fractured tooth)	$40
D2971	Additional procedures to construct new crown under existing partial denture framework	$50
D2980	Crown repair necessitated by restorative material failure	$0

CDT Code	Benefit	Copay
D2981	Inlay repair necessitated by restorative material failure	$0
D2982	Onlay repair necessitated by restorative material failure	$0
D2983	Veneer repair necessitated by restorative material failure	$0
D2990	Resin infiltration of incipient smooth surface lesions	$7
Endodontic Services		
D3110	Pulp cap – direct (excluding final restoration)	$5
D3120	Pulp cap – indirect (excluding final restoration)	$5
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$20
D3221	Pulpal debridement, primary and permanent teeth	$25
D3310	Endodontic (root canal) therapy, anterior (front) tooth (excluding final restoration)	$90
D3320	Endodontic (root canal) therapy, bicuspid tooth (excluding final restoration)	$125
D3330	Endodontic (root canal) therapy, molar (three or four canals, excluding final restoration)	$160
D3346	Retreatment of previous root canal therapy – anterior (front)	$90
D3347	Retreat of previous root canal therapy (bicuspid)	$125
D3348	Retreat of previous root canal therapy (molar)	$160
D3410	Apicoectomy/periradicular surgery – anterior (front)	$95
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	$95
D3425	Apicoectomy/periradicular surgery – molar (first root)	$95
D3426	Apicoectomy/periradicular surgery – additional root	$45
D3430	Retrograde filling (per root)	$75
Periodontic Services		
D4210	Gingivectomy/gingivoplasty – four+ contiguous (adjoining) teeth/tooth-bounded spaces per quadrant	$95
D4211	Gingivectomy/gingivoplasty – one to three contiguous (adjoining) teeth/tooth-bounded spaces per quadrant	$48
D4212	Gingivectomy/gingivoplasty to allow access for restorative procedure – per tooth	$48
D4260	Osseous surgery (including flap entry and closure) – four+ contiguous (adjoining) teeth/tooth-bounded spaces per quadrant	$240
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous (adjoining) teeth or tooth-bounded spaces per quadrant	$150
D4268	Surgical revision procedure, per tooth	$0
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$38
D4342	Periodontal scaling and root planing, one to three teeth per quadrant during any calendar year	$23
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$35
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$50
D4910	Periodontal maintenance	$25
D4920	Unscheduled dressing change, by someone other than treating dentist	$0

CDT Code	Benefit	Copay
Prosthodontic Services (Removable)		
D5110	Complete denture upper – maxillary	$175
D5120	Complete denture lower – mandibular	$175
D5130	Immediate denture upper – maxillary	$175
D5140	Immediate denture lower – mandibular	$175
D5211	Maxillary (upper) partial denture – resin base (including any conventional clasps, rests and teeth)	$150
D5212	Mandibular (lower) partial denture – resin base (including any conventional clasps, rests and teeth)	$150
D5213	Maxillary (upper) partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$150
D5214	Mandibular (lower) partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$150
D5225	Maxillary (upper) partial denture – flexible base (including any clasps, rests and teeth)	$365
D5226	Mandibular (lower) partial denture – flexible base (including any clasps, rests and teeth)	$365
D5410	Adjust complete denture – maxillary (upper)	$0
D5411	Adjust complete denture – mandibular (lower)	$0
D5421	Adjust partial denture – maxillary (upper)	$0
D5422	Adjust partial denture – mandibular (lower)	$0
D5510	Repair broken complete denture base	$30
D5520	Replace missing or broken teeth – complete denture (each tooth)	$25
D5610	Repair resin denture base	$30
D5620	Repair cast framework	$30
D5630	Repair or replace broken clasp	$25
D5640	Replace broken teeth – per tooth	$25
D5650	Add tooth to existing partial denture	$30
D5660	Add clasp to existing partial denture	$40
D5670	Replace all teeth and acrylic on cast metal framework – maxillary (upper)	$125
D5671	Replace all teeth and acrylic on cast metal framework – mandibular (lower)	$125
D5710	Rebase complete maxillary (upper) denture	$75
D5711	Rebase complete mandibular (lower) denture	$75
D5720	Rebase maxillary (upper) partial denture	$75
D5721	Rebase mandibular (lower) partial denture	$75
D5730	Reline complete maxillary (upper) denture (chairside)	$40
D5731	Reline complete mandibular (lower) denture (chairside)	$40
D5740	Reline maxillary (upper) partial denture (chairside)	$40
D5741	Reline mandibular (lower) partial denture (chairside)	$40

CDT Code	Benefit	Copay
D5750	Reline complete maxillary (upper) denture (lab)	$65
D5751	Reline complete mandibular (lower) denture (lab)	$65
D5760	Reline maxillary (upper) partial denture (lab)	$65
D5761	Reline mandibular (lower) partial denture (lab)	$65
D5810	Interim complete denture – maxillary (upper)	$175
D5811	Interim complete denture – mandibular (lower)	$175
D5820	Interim partial denture – maxillary (upper)	$70
D5821	Interim partial denture – mandibular (lower)	$70
D5850	Tissue conditioning – maxillary (upper)	$0
D5851	Tissue conditioning – mandibular (lower)	$0
Prosthodontic Services (Fixed)		
D6205	Pontic (bridge) – indirect resin-based composite	$150
D6210	Pontic (bridge) – cast high noble metal	$150*
D6211	Pontic (bridge) – cast predominantly base metal	$150*
D6212	Pontic (bridge) – cast noble metal	$150*
D6214	Pontic (bridge) – titanium	$150*
D6240	Pontic (bridge) – porcelain fused to high noble metal	$175*
D6241	Pontic (bridge) – porcelain fused to predominantly base metal	$175*
D6242	Pontic (bridge) – porcelain fused to noble metal	$175*
D6245	Pontic (bridge) – porcelain/ceramic	$175*
D6250	Pontic (bridge) – resin w/ high noble metal	$150*
D6251	Pontic (bridge) – resin w/ predominantly base metal	$150*
D6252	Pontic (bridge) – resin w/ noble metal	$150*
D6253	Provisional pontic (bridge) – further treatment or completion of diagnosis necessary prior to final impression	$150
D6545	Retainer – cast metal for resin-bonded fixed prosthesis	$100
D6548	Retainer – porcelain/ceramic for resin-bonded fixed prosthesis	$100*
D6600	Inlay – porcelain/ceramic , two surfaces	$155*
D6601	Inlay – porcelain/ceramic three or more surfaces	$155*
D6602	Inlay – cast high noble metal, two surfaces	$130*
D6603	Inlay – cast high noble metal, three or more surfaces	$130*
D6604	Inlay – cast predominantly base metal, two surfaces	$130*
D6605	Inlay – cast base metal, three or more surfaces	$130*
D6606	Inlay – cast noble metal, two surfaces	$130*
D6607	Inlay – cast noble metal, three or more surfaces	$130*
D6608	Onlay – porcelain/ceramic, two surfaces	$145*
D6609	Onlay – porcelain/ceramic, three or more surfaces	$145*
D6610	Onlay – cast high noble metal, two surfaces	$140*
D6611	Onlay – cast high noble metal, three or more surfaces	$140*
D6612	Onlay – cast predominantly base metal, two surfaces	$140*
D6613	Onlay – cast predominantly base metal, three or more surfaces	$145*
D6614	Onlay – cast noble metal, two surfaces	$140*
D6615	Onlay – cast noble metal, three or more surfaces	$140*
D6624	Inlay – titanium	$130*
D6634	Onlay – titanium	$130*
D6710	Crown – indirect resin-based composite	$150
D6720	Crown – resin w/ high noble metal	$150*
D6721	Crown – resin w/ predominantly base metal	$150*
D6722	Crown – resin w/ noble metal	$150*
D6740	Crown – porcelain/ceramic	$175*
D6750	Crown – porcelain fused to high noble metal	$175*
D6751	Crown – porcelain fused to predominately base metal	$175*
D6752	Crown – porcelain fused to noble metal	$175*
D6780	Crown – 3/4 cast high noble metal	$150*
D6781	Crown – 3/4 cast predominately base metal	$150*
D6782	Crown – 3/4 cast noble metal	$150*
D6783	Crown – 3/4 porcelain/ceramic	$150*
D6790	Crown – full cast high noble metal	$150*
D6791	Crown – full cast predominantly base metal	$150*
D6792	Crown – full cast noble metal	$150*
D6794	Crown – titanium	$150*
D6930	Re-cement fixed partial denture	$10
D6940	Stress breaker	$90
D6980	Fixed partial denture (bridge) repair necessitated by restorative material failure	$0
Oral and Maxillofacial Surgery Services		
D7111	Extraction, coronal remnants – deciduous tooth	$0
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$15
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$30
D7220	Removal of impacted tooth – soft tissue	$50
D7230	Removal of impacted tooth – partial bony	$70
D7240	Removal of impacted tooth – completely bony	$100
D7241	Removal of impacted tooth – completely bony w/unusual surgical complications	$115
D7250	Surgical removal of residual tooth roots (cutting procedure)	$50
D7280	Surgical access of an unerupted tooth	$140
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$15
D7283	Placement of device to facilitate eruption of impacted teeth	$25
D7285	Biopsy of oral tissue – hard (bone, tooth)	$50
D7286	Biopsy of oral tissue – soft	$50
D7288	Brush biopsy – transepithelial sample collection	$45
D7310	Alveoplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$25
D7311	Alveoplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$25
D7320	Alveoplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$25
D7321	Alveoplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$25
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	$200
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	$425
D7471	Removal of lateral exostosis (maxilla or mandible)	$100
D7472	Removal of torus palatinus	$100

CDT Code	Benefit	Copay
D7473	Removal of torus mandibularis	$100
D7485	Surgical reduction of osseous tuberosity	$60
D7510	Incision and drainage of abscess – intraoral soft tissue	$25
D7511	Incision and drainage of abscess – intraoral soft tissue, complicated (includes drainage of multiple fascial spaces)	$40
D7520	Incision and drainage of abscess – extraoral soft tissue	$45
D7521	Incision and drainage of abscess – extraoral soft tissue, complicated (includes drainage of multiple fascial spaces)	$125
D7910	Suture of recent small wounds up to 5 cm	$75
D7960	Frenulectomy (also frenectomy or frenotomy) – separate procedure not incidental to another	$60
D7963	Frenuloplasty	$30
D7970	Excision of hyperplastic tissue (per arch)	$75
D7971	Excision of pericoronal gingiva	$35
Orthodontic Services**		
D8070	Comprehensive treatment of the transitional dentition	$1,695
D8080	Comprehensive treatment of the adolescent dentition	$1,695
D8090	Comprehensive treatment of adult dentition	$1,895
D8660	Pre-orthodontic treatment visit	$0
D8680	Orthodontic retention (placement of retainers	$200

CDT Code	Benefit	Copay
Other Services		
D9110	Palliative (emergency) treatment of dental pain – minor procedures	$15
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0
D9220	Deep sedation/general anesthesia – first 30 minutes	$160
D9221	Deep sedation/general anesthesia – add'l 15 minutes	$65
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$15
D9241	Intravenous conscious sedation/analgesia – first 30 minutes	$160
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes	$65
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	$0
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	$0
D9440	Office visit after regularly scheduled hours	$25
D9630	Other drugs and/or medications, by report	$30
D9930	Treatment of postsurgical complications – unusual circumstances, by report	$30
D9940	Occlusal guard, by report	$100

* There is a charge of $125 when using precious metals. This is in addition to your copayment. There is a $100 charge in addition to your copayment for porcelain to metal crowns placed on molars

**Twenty-four months of standard orthodontic care, exclusive of records/retention fees.

[1] Pediatric dental services provided by a pediatric dentist have an annual maximum of $750 and are limited to children through the age of 5.

Participating Dental Net Dental HMO Providers

Participating Dental Net providers are dentists who have contracted with us to provide you with dental services covered under this plan. Your selected dentist will diagnose and treat most of your dental conditions and will coordinate all your dental care – referring you to specialists when necessary. With the exception of out-of-area emergency services, all of your dental care needs must be provided by, or coordinated through, your selected dental office in order to be covered by your dental plan. Services provided by nonparticipating providers (dentists who are not contracted as part of the Dental Net Dental HMO network) **are not covered** under this plan, except for limited coverage of emergency services.

Finding a dentist is easy – We have a large network of dentists from which to choose.

To select a dentist by name or location:

- Go to www.anthem.com/ca and click on **FIND A DOCTOR** (Dentist, Pharmacy, or Hospital)
- Call Dental Customer Service at 888-209-7852

To Contact Us:

Call	Write	Email
Call the toll-free number on the back of your plan ID card or call 888-209-7852 to speak with a U.S.-based customer service representative during normal business hours. If you are calling after hours, we may still be able to assist you with our interactive voice-response system at 888-209-7852.	Refer to the back of your ID card for the claims submission address.	dentalhelp@anthem.com You may also visit our Web site at: **anthem.com/ca**

Limitations and Exclusions

Limitations – Below is a partial listing of plan limitations. Please see your Evidence of Coverage for a full list.

Unauthorized Services Dental services must be received from the member's participating dental office unless an exception is specifically authorized by the member's participating dental office and/or Anthem Blue Cross, in writing.
Out-of-area emergency dental care is reimbursed up to $100, less any applicable copayments.
Professionally Acceptable Treatment In cases where multiple acceptable methods of treatment exist, the least expensive professionally acceptable treatment is considered the covered benefit.
Periodontal Procedures

- Periodontal scaling and root planing is limited to one course of therapy per quadrant during every calendar year.
- Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis is limited to one course of treatment per lifetime.

Prosthodontic Replacement
1. Partial dentures are not eligible for replacement within five (5) years of original placement unless required as a result of additional tooth loss, which cannot be restored by modification of the existing partial denture.
2. Crowns, bridges, inlays and/or complete dentures are not eligible for replacement within five (5) years of original placement.
Denture Relines Complete and/or partial denture relines or rebases are limited to one per denture every calendar year.
Denture Replacement Dentures, full or partial - replacements will be made only if existing denture is five (5) years old and cannot be made serviceable.
Seven (7) or more crowns If a treatment plan involves seven (7) or more crowns and/or fixed bridge units, an additional charge of $125 per tooth or artificial tooth will be charged for all teeth and artificial teeth.
Precious Metals The use of alloys/noble metal for any restorative procedure is considered optional and if used, the additional cost for such alloy will be the Members financial responsibility up to $125.
Porcelain on molars If porcelain to metal crowns are placed on molars, as additional charge of $100.00 per tooth will be chargeable to the member.
Extractions 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.
Sealants are limited to children under sixteen (16) years of age for permanent unrestored molars. Treatment is limited to once per tooth every 36 months.
Oral Exams are limited to two (2) per calendar year.
General Anesthesia and IV Sedation Covered only when given with the removal on or more impacted teeth (completely bony). Subject to preauthorization.

Exclusions – Below is a partial listing of noncovered services. Please see your Evidence of Coverage for a full list.

Cosmetic Services Dental care that is only to improve your appearance when tooth structure and function are satisfactory and no pathologic conditions (decay) exist.
Workers' Compensation Any condition for which benefits of any nature are recoverable, whether by adjudication or settlement, under any workers' compensation or occupational disease law, even if you did not claim those benefits.
If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, benefits will be provided subject to our right of recovery and reimbursement under California Labor Code Section 4903.
Government Programs Care or treatment which is obtained from, or for which payment is made by any Federal, State, or other government agency, including any foreign government.
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 dental care that cannot be performed in the participating dental office because of your general health, mental or emotional behavior, or physical limitations.
Lost or Stolen Dentures or Appliances Replacement of crowns, dentures, bridgework, or other dental appliances that have been lost, stolen or damaged due to misuse or neglect..
Services Provided Before or After Your Term of Coverage Dental care you receive either before your effective date or after your coverage ends.
Dental Care Outside of the Dental Net Network Except as provided in the section How To Get Emergency Care When You Need It of your Evidence of Coverage, services given by a dentist or dental office that is not part of the Dental Net network will not be covered. Also, we will not cover services that are needed as a result of dental care given by a dentist or dental office that is not a part of the Dental Net network.
Congenital (hereditary) or Developmental Malformations Treatment of congenital or developmental malformations including, but not limited to, enamel hypoplasia, flourosis, supernumerary 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, vestibuloplasty, or ostectomy procedures.
Prosthetic Services Age Limitations Space maintainers for members over age twelve (12).
Not Generally Accepted Procedures which are considered experimental or investigative or which are not generally accepted standards of dental practice within the organized dental community.
Implants Dental procedures and charges incurred as part of implants or the removal of implants. 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).
Vertical Dimension and Attrition Procedures requiring (other than those for replacement of structure lost due to dental decay) that are necessary to alter, restore or maintain occlusion. Exclusion does not apply to alteration by removable prosthodontics.
Periodontal Splinting Services for or relating to periodontal splinting.
Treatment of the Joint of the Jaw Diagnosis or treatment by any method of any condition related to the jaw joint (temporomandibular joint) or associated musculature, nerves and other tissues.
Not Medically Necessary Services or supplies that are not considered medically necessary.
Services Not Listed. Dental care services that are not specifically listed in the Schedule of Copayments in your Evidence of Coverage.
Crown Lengthening Crown exposure, ligation and crown lengthening are not covered.
Removal of Third Molars Immature erupting third molars and non-pathologic asymptomatic third molars are not covered for extraction.
Primary Restorations Gold, porcelain or resin fillings on primary teeth are excluded.
Poor Prognosis Endodontic treatment, periodontal surgery, or crown/bridge work is not covered on teeth with questionable, guarded or poor prognosis. We will allow for observation or extraction and prosthetic replacement.
Precision Attachments Services for precision attachments.
Orthodontic Pretreatment Any treatment or services that your dentist deems necessary or advantageous in order to begin standard orthodontic treatment.
Orthodontic Treatment in Progress. Orthodontic treatment that was started before your effective date under this plan or after your coverage ends.

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 the dental certificate. In the event of a discrepancy between the information contained in this benefit summary and that in the dental certificate, the dental certificate will prevail. The in-network dentists mentioned in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of Anthem Blue Cross.

Summary of Benefits
Anthem Dental Essential Choice
Good-Nite Inn, Inc
Anthem Dental Complete Network

WELCOME TO YOUR DENTAL PLAN!

Regular dental checkups can help find early warning signs of certain health problems, which means you can get the care you need to get healthy. So, don't skimp on your dental care, good oral care can mean better overall health!

Powerful and easily accessible member tools.

- **Ask a Hygienist:** Dental members can simply email their dental questions to a team of licensed dental professionals who in turn will respond in about 24 hours.
- **Dental Health Risk Assessment:** We want our dental members to better understand their oral health and their risk factors for tooth decay, gum disease and oral cancer. This easy to use online tool can help them do this.
- **Dental Care Cost Estimator:** In order to help our dental member better understand the cost of their dental care, we offer access to a user-friendly, web-based tool that provides estimates on common dental procedures and treatments when using a network dentist.
- **More Capabilities:** With our latest mobile application, Anthem Anywhere, members can find a network dentist as well as view their claims. It's available both for Android and Apple phones.

Dentists in your plan network.

- You'll save money when you visit a dentist in your plan network because Anthem and the dentist have agreed on pricing for covered services. Dentists who are not in your plan network have not agreed to pricing, and may bill you for the difference between what Anthem pays them and what the dentist usually charges.
- To find a dentist by name or location, go to anthem.com or call dental customer service at the number listed on the back of your ID card.

Ready to use your dental benefits?

- Choose a dentist from the network
- Make an appointment
- Show the office staff your member ID card
- Pay any deductible or copay that is part of your plan

Need to contact us?

See the back of your ID card for who to call, write or email.

Your dental benefits at a glance

The following 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 policy.

		In-Network	Out-of-Network
Annual Benefit Maximum	Calendar Year		
· Per insured person		**$2,250**	**$2,250**
D&P applies to Annual Maximum		**Yes**	**Yes**
Annual Maximum Carryover / Carry in		**Yes/Yes**	**Yes/Yes**
Orthodontic Lifetime Benefit Maximum			
· Per eligible insured person		**$2,000**	**$2,000**
Annual Deductible (Does not apply to Orthodontic Services)			
· Per insured person/Family maximum	Calendar Year	**$0/3X Individual**	**$50/3X Individual**
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		100% Coinsurance	100% Coinsurance	No Waiting Period
· Periodic oral exam	2 per 12 months			
· Teeth cleaning (prophylaxis)	2 per 12 months; w/periodontal maintenance			
· Bitewing X-rays:	1 set per 12 months			
· Full-mouth or Panoramic X-rays:	1 per 60 months			
· Fluoride application:	1 per 12 months through age 18			
· Sealants	1 per 60 months; through age 18			
Basic Services		90% Coinsurance	80% Coinsurance	No Waiting Period
· Consultation (second opinion)	1 per 12 months			
· Space Maintainer	1 per lifetime through age 18; posterior teeth			
· Amalgam (silver-colored) Filling	1 per tooth per 24 months			
· Composite (tooth-colored) Filling	1 per tooth per 24 months			
posterior (back) fillings alternated to amalgam benefit (silver-colored filling)				
· Brush Biopsy (cancer test)	Covered, 1 per 12 months; all ages			
Endodontics (Non-Surgical)		90% Coinsurance	80% Coinsurance	No Waiting Period
· Root Canal and retreatments	1 per tooth per lifetime			
Endodontics (Surgical)		90% Coinsurance	80% Coinsurance	No Waiting Period
· Apicoectomy and apexification	1 per tooth per lifetime			
Periodontics (Non-Surgical)		90% Coinsurance	80% Coinsurance	No Waiting Period
· Periodontal Maintenance	4 per 12 months; w/teeth cleaning			
· Scaling and root planing	1 per quadrant per 24 months			
Periodontics (Surgical)	1 per quadrant per 36 months	90% Coinsurance	80% Coinsurance	No Waiting Period
· Periodontal Surgery (osseous, gingivectomy, graft procedures)				
Oral Surgery (Simple)		90% Coinsurance	80% Coinsurance	No Waiting Period
· Simple Extractions	1 per tooth per lifetime			
Oral Surgery (Complex)		90% Coinsurance	80% Coinsurance	No Waiting Period
· Surgical Extractions	1 per tooth per lifetime			
Major (Restorative) Services & Prosthodontics		60% Coinsurance	50% Coinsurance	12 Month
· Crowns, veneers, dentures, and bridges	1 per tooth per 84 months			
· Dental implants	Covered, 1 per tooth per 84 months			
· Cosmetic teeth whitening	Not Covered			
Prosthodontic Repairs/Adjustments		60% Coinsurance	50% Coinsurance	12 Month
· Crown, denture, bridge repairs	1 per 12 months; 6 months after placement			
· Denture and bridge adjustments:	2 per 12 months; 6 months after placement			
Orthodontic Services				
·Adults & Dependent Children		50% Coinsurance	50% Coinsurance	12 Month

*Child orthodontic coverage begins at age eight and runs through age 26. This means that the child must have been banded between the ages of 8 and 27 in order to receive coverage.

Additional Services and Programs

Anthem Whole Health Connection -Dental

- For members with certain health conditions, additional dental benefits are available without a deductible or waiting periods. Eligible services are paid at 100% and won't reduce your coverage year annual maximum (if applicable)

Accidental Dental Injury Benefit

- Provides members 100% coverage for accidental injuries to teeth up to the coverage year annual maximum (if applicable). No deductibles, member coinsurance, or waiting periods apply

Extension of Benefits

- Following termination of coverage, members are provided up to 60 days to complete treatment started prior to their termination of coverage under the plan and eligible services will be covered

International Emergency Dental Program

- Provides emergency dental benefits while working or traveling abroad from licensed, English-speaking dentists. Eligible covered services will be paid 100% with no deductibles, member coinsurance, or waiting periods and won't reduce the member coverage year annual maximum (if applicable)

Additional Limitations & Exclusions

Below is a partial listing of non-covered services under your dental plan. Please see your policy 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) including orthodontic braces, appliances and all related services

Cosmetic dentistry (unless included as part of your dental plan benefits) 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 including intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care

Analgesia, analgesic agents, and 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 of third molars (wisdom teeth) that do not exhibit pathology symptoms or impact the oral health of the member

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

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 certificate of coverage. In the event of a discrepancy between the information in this summary and the certificate of coverage, the certificate will prevail.

Blue View Vision℠

Plan BV6A

Anthem BlueCross

Welcome to your Blue View Vision plan!

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice doctors, local optical stores, and national retail stores including LensCrafters®, Target Optical®, Sears Optical® and JCPenney® Optical. You may also use your in-network benefits to order eyewear online at Glasses.com and ContactsDirect.com. To locate a participating network eye care doctor or location, log in at **anthem.com/ca**, or from the home page menu under Care, select **Find a Doctor**. You may also call member services for assistance at **1-866-723-0515**.

Out-of-Network – If you choose to, you may instead receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance.

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Routine Eye Exam			
A comprehensive eye examination	$10 copay	Up to $49 reimbursement	Once every 12 months
Eyeglass Frames			
One pair of eyeglass frames	$130 allowance, then 20% off any remaining balance	Up to $50 reimbursement	Once every 12 months
Eyeglass Lenses *(instead of contact lenses)*			
One pair of standard plastic prescription lenses: • Single vision lenses • Bifocal lenses • Trifocal lenses	 $25 copay $25 copay $25 copay	 Up to $35 reimbursement Up to $49 reimbursement Up to $74 reimbursement	Once every 12 months
Eyeglass Lens Enhancements When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost.			
• Transitions Lenses (for a child under age 19) • Standard polycarbonate (for a child under age 19) • Factory scratch coating	$0 copay $0 copay $0 copay	No allowance when obtained out-of-network	Same as covered eyeglass lenses
Contact Lenses *(instead of eyeglass lenses)* Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.			
• Elective conventional (non-disposable) OR • Elective disposable OR • Non-elective (medically necessary)	$130 allowance, then 15% off any remaining balance $130 allowance *(no additional discount)* Covered in full	Up to $92 reimbursement Up to $92 reimbursement Up to $250 reimbursement	Once every 12 months

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview. This benefit overview is only one piece of your entire enrollment package.

EXCLUSIONS & LIMITATIONS (not a comprehensive list – please refer to the member Certificate of Coverage for a complete list)

Combined Offers. Not to be combined with any offer, coupon, or in-store advertisement.
Excess Amounts. Amounts in excess of covered vision expense.
Sunglasses. Plano sunglasses and accompanying frames.
Safety Glasses. Safety glasses and accompanying frames.
Not Specifically Listed. Services not specifically listed in this plan as covered services.
Lost or Broken Lenses or Frames. Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.
Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.
Orthoptics. Orthoptics or vision training and any associated supplemental testing.

OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY		In-network Member Cost (after any applicable copay)
Retinal Imaging - at member's option can be performed at time of eye exam		Not more than $39

Eyeglass lens upgrades
When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.
	• Transitions lenses (Adults)
	• Standard Polycarbonate (Adults)
	• Tint (Solid and Gradient)
	• UV Coating
	• Progressive Lenses[1]
	  • Standard
	  • Premium Tier 1
	  • Premium Tier 2
	  • Premium Tier 3
	• Anti-Reflective Coating[2]
	  • Standard
	  • Premium Tier 1
	  • Premium Tier 2
	• Other Add-ons
		$75
		$40
		$15
		$15
		
		$65
		$85
		$95
		$110
		
		$45
		$57
		$68
		20% off retail price

Additional Pairs of Eyeglasses Anytime from any Blue View Vision network provider.	• Complete Pair • Eyeglass materials purchased separately	40% off retail price 20% off retail price
Eyewear Accessories	• Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail price
Contact lens fit and follow-up A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.	• Standard contact lens fitting[3] • Premium contact lens fitting[4]	Up to $55 10% off retail price
Conventional Contact Lenses	• Discount applies to materials only	15% off retail price

[1] Please ask your provider for his/her recommendation as well as the available progressive brands by tier.

[2] Please ask your provider for his/her recommendation as well as the available coating brands by tier.

[3] Standard fitting includes spherical clear lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

[4] Premium fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

Discounts are subject to change without notice. Discounts are not 'covered benefits' under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where state law prevents discounting of products and services that are not covered benefits under the plan. Discounts on frames will not apply if the manufacturer has imposed a no discount policy on sales at retail and independent provider locations. Some of our in-network providers include:

GLASSES.COM · contactsdirect · LensCrafters · OPTICAL · sears OPTICAL · JCPenney | optical

ADDITIONAL SAVINGS AVAILABLE THROUGH ANTHEM'S SPECIAL OFFERS PROGRAM *

Savings on items like additional eyewear after your benefits have been used, non-prescription sunglasses, hearing aids and even LASIK laser vision correction surgery are available through a variety of vendors. Just **log in at anthem.com/ca**, select discounts, then Vision, Hearing & Dental.

* Discounts cannot be used in conjunction with your covered benefits.

OUT-OF-NETWORK

If you choose to receive covered services or purchase covered eyewear from an out-of-network provider, network discounts will not apply and you will be responsible for payment of services and/or eyewear materials at the time of service. Please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. To download a claim form, log in at **anthem.com/ca**, or from the home page menu under Support select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at **1-866-723-0515** to request a claim form.

To Fax: 866-293-7373
To Email: oonclaims@eyewearspecialoffers.com
To Mail: Blue View Vision
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

BV6A

Skip the drugstore – have your medicine delivered to your home!

Why wait in line at the drugstore if you don't have to? If you take prescribed medicine on a regular basis, you can get up to a 90-day supply delivered to your door.[1] And depending on your plan, you may save on copays because the cost of a 90-day supply of many drugs is usually less than three 30-day refills. On average, members save up to 25% on their copay when they use home delivery.[2] Standard shipping is free, and you can even set up automatic refills.

Getting started with home delivery is easy:

1. Go online to get a prescription order form.

Visit anthem.com/ca, choose **Manage Your Prescriptions** from the home page and log in with your username and password. If you haven't signed up on the site yet, you'll need to do that first.

On your personal pharmacy page, select **Start a New Prescription**.

That'll take you to the site of the company that helps manage our prescription benefits.[3] There, you can download and print the **physician fax form** or, if you already have a new prescription for a 90-day supply of medicine from your doctor, download the home delivery mail form. You'll use one of these forms to send in your prescription.

2. Get a new prescription from your doctor for home delivery.

You'll need an up-to-90-day supply prescription. Your doctor can send in your prescription through eprescribe or fax it using the **physician fax form** from step 1.

Also ask your doctor for a 30-day prescription. Get this filled at your regular pharmacy to make sure you have enough medicine to last until you get your first home delivery prescription.

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Need help?

Call the home delivery pharmacy at 1-866-297-1013 and we'll get you started.

3. Send in your prescription

Fill out the home delivery order form and mail it to the address on the form. Be sure to include prescription and payment information along with it.

or

Your doctor can fill out the physician fax form and fax or efax it to the number on the form.

4. Pay for your prescription.

You can pay by check, echeck, money order, credit or debit card, flexible spending account or health savings account.

You can sign up for e-payments or have your credit card on file online. To set up your payments, go to anthem.com/ca, choose **Manage Your Prescriptions** from the home page and log in. Then, select **Start a New Prescription**. Once you're on our prescription benefit manager's site, select **My Account** to choose how you'd like to pay.

If you want to use our Home Delivery Pharmacy and are enrolled in a program that helps you with your copay or if you use manufacturer coupons to help pay for prescriptions, you'll need to give the program or manufacturer detailed claim information and a receipt to get paid back. The company that manages our prescription benefits can't bill us or these third parties for prescriptions you fill through home delivery.

A few important things to know

- If your doctor prescribes a brand-name drug, your pharmacy plan may require the home delivery pharmacy to send a generic version instead.
- All prescriptions and refills, including those sent by your doctor, will be filled as soon as the home delivery pharmacy gets them.
- In most cases, your first order will arrive within two weeks after the home delivery pharmacy gets it. After that, the orders will arrive within one week.
- If you need your medicine sooner, you can call the home delivery pharmacy and ask for overnight delivery. It will still take 3 to 5 days to process the order, plus the shipping time. You'll be charged extra for the faster shipping.
- Your orders will be delivered by the U.S. Postal Service, UPS or FedEx.
- With some drugs, you may need to sign to accept delivery.[4]

1 Supplies are based on your pharmacy plan design.
2 Express Scripts internal data, 2017.
3 Express Scripts is a separate company that manages pharmacy services for our health plan members.
4 Drugs that are defined as controlled substances are highly regulated, which requires the home delivery pharmacy to follow special rules for filling these prescriptions.

Take care of yourself
Use your preventive care benefits

Anthem BlueCross

Getting regular checkups and exams can help you stay healthy and catch problems early — when they're easier to treat.

That's why our health plans offer all the preventive care services and immunizations below — at no cost to you.[1] As long as you see a doctor or use a pharmacy in the plan, you won't have to pay anything for these services and immunizations. If you want to visit a doctor or pharmacy outside the plan, you may have to pay out of pocket.

Not sure which services make sense for you? Talk to your doctor. He or she can help you figure out what you need.

Preventive vs. diagnostic care

What's the difference? Preventive care helps protect you from getting sick. If your doctor recommends you have services even though you have no symptoms, that's preventive care. Diagnostic care is when you have symptoms and your doctor recommends services to determine what's causing those symptoms.

Adult preventive care

Preventive physical exams

Screening tests:

- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit, and computed tomography (CT) colonography (as appropriate)
- Depression screening
- Hepatitis C virus (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965
- Type 2 diabetes screening*
- Eye chart test for vision[2]
- Hearing screening
- Height, weight and body mass index (BMI)
- HIV screening and counseling
- Lung cancer screening for those ages 55-80 who have a history of smoking 30 packs per year and still smoke, or quit within the past 15 years[3]
- Obesity: related screening and counseling*
- Prostate cancer, including digital rectal exam and prostate-specific antigen (PSA) test
- Sexually transmitted infections: related screening and counseling
- Tobacco use: related screening and behavioral counseling
- Violence, interpersonal and domestic: related screening and counseling

Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Hepatitis A and hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps and rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Varicella (chickenpox)
- Zoster (shingles)

Women's preventive care:

- Well-woman visits
- Breast cancer, including exam, mammogram, and genetic testing for BRCA 1 and BRCA 2 when certain criteria are met[4]
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies and counseling[5,6,7]
- Contraceptive (birth control) counseling
- Food and Drug Administration (FDA)-approved contraceptive medical services, including sterilization, provided by a doctor
- Counseling related to chemoprevention for those with a high risk of breast cancer
- Counseling related to genetic testing for those with a family history of ovarian or breast cancer
- HPV screening[6]
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings, including gestational diabetes, hepatitis B, asymptomatic bacteriuria, Rh incompatibility, syphilis, HIV and depression[6]
- Pelvic exam and Pap test, including screening for cervical cancer

These preventive care services are recommendations of the Affordable Care Act (ACA or health care reform law). They may not be right for every person, so ask your doctor what's right for you.

This sheet is not a contract or policy with Anthem Blue Cross. If there is any difference between this sheet and the group policy, the provisions of the group policy will rule. Please see your combined Evidence of Coverage and Disclosure Form or Certificate for exclusions and limitations.

* CDC-recognized Diabetes Prevention programs are available for overweight or obese adults with abnormal blood glucose or who have abnormal CVD risk factors.

Child preventive care

Preventive physical exams

Screening tests:

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Development and behavior screening
- Type 2 diabetes screening
- Hearing screening
- Height, weight and BMI
- Hemoglobin or hematocrit (blood count)
- HPV screening (female)
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Counseling for those ages 10–24 with fair skin about lowering their risk for skin cancer
- Oral (dental health) assessment when done as part of a preventive care visit
- Screening and counseling for sexually transmitted infections
- Tobacco use: related screening and behavioral counseling
- Vision screening when done as part of a preventive care visit[2]

Immunizations:

- Chickenpox
- Flu
- Haemophilus influenza type b (Hib)
- Hepatitis A and hepatitis B
- HPV
- Meningitis
- MMR
- Pneumonia
- Polio
- Rotavirus
- Whooping cough

A word about pharmacy items

For 100% coverage of your over-the-counter (OTC) drugs and other pharmacy items listed here, you must:

- Meet certain age requirements and other rules.
- Get prescriptions from plan providers and fill them at plan pharmacies.
- Have prescriptions, even for OTC items.

Child preventive drugs and other pharmacy items — age appropriate:

- Dental fluoride varnish to prevent the tooth decay of primary teeth for children ages 0-5
- Fluoride supplements for children ages 0-6

Adult preventive drugs and other pharmacy items — age appropriate:

- Aspirin use (81 mg and 325 mg) for the prevention of cardiovascular disease, preeclampsia and colorectal cancer by adults less than 60 years old
- Colonoscopy prep kit (generic or OTC only) when prescribed for preventive colon screening
- Tobacco-cessation products, including select generic prescription drugs, select brand-name drugs with no generic alternative and FDA-approved OTC products, for those ages 18 and older
- Vitamin D for adults over age 65

Women's preventive drugs and other pharmacy items — age appropriate:

- Contraceptives, including generic prescription drugs, brand-name drugs with no generic alternative and OTC items like female condoms and spermicides[6,8,9]
- Low-dose aspirin (81 mg) for pregnant women who are at increased risk of preeclampsia
- Folic acid for women ages 55 or younger who are planning and able to get pregnant
- Breast cancer risk-reducing medications, such as tamoxifen and raloxifene, that follow the U.S. Preventive Services Task Force criteria[3]

1 The range of preventive care services covered at no cost share when provided by plan doctors is designed to meet state and federal requirements. The Department of Health and Human Services decided which services to include for full coverage based on U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by Health Resources and Services Administration (HRSA) Guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your Certificate of Coverage or call the Member Services number on your ID card.

2 Some plans cover additional vision services. Please see your contract or Certificate of Coverage for details.

3 You may be required to get preapproval for these services.

4 Check your medical policy for details.

5 Breast pumps and supplies must be purchased from plan providers for 100% coverage. We recommend using plan durable medical equipment (DME) suppliers.

6 This benefit also applies to those younger than age 19.

7 Counseling services for breastfeeding (lactation) can be provided or supported by a plan doctor or hospital provider, such as a pediatrician, obstetrician/gynecologist or family medicine doctor, and hospitals with no member cost share (deductible, copay, coinsurance). Contact the provider to see if such services are available.

8 A cost share may apply for other prescription contraceptives, based on your drug benefits.

9 Your cost share may be waived if your doctor decides that using the multisource brand is medically necessary

Notes

Notes

We've got your back!

Anthem BlueCross

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídiiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilnį. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilnį.

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

아직 가입하지 않았거나 한국어로 된 도움말이 필요한 경우 영업 관리자나 그룹 관리자에게 문의하시기 바랍니다. 이미 가입한 경우 ID 카드에 있는 번호를 사용하여 고객 서비스에 문의하시기 바랍니다.

Nếu quý vị chưa phải là một hội viên và cần được giúp đỡ bằng Tiếng Việt, xin liên lạc với đại diện thương mãi của quý vị hoặc quản trị viên nhóm. Nếu quý vị đã ghi danh, xin liên lạc với dịch vụ khách hàng qua việc dùng số điện thoại ghi trên thẻ ID của quý vị.