Dental Blue Basic and Essential
Ohio Individual

	Dental Blue Basic 100	Dental Blue Essential 100 and 200
Annual Deductible Per Member / Per Year Combined In and Out of Network	$50 member pays	$50 member pays
Annual Maximum Amount of benefits available to a member during the year	$500	$1,000
Waiting Periods	No waiting period	12 month waiting period Major Restorative
Network	100	Dental Blue Essential 100 uses 100 network Dental Blue Essential 200 uses 200 network

	Dental Blue Basic 100		Dental Blue Essential 100 and 200	
Where to Receive Services	PPO Dentists In-network	Out-of-network	PPO Dentists In-network	Out-of-network
Diagnostic and Preventive	100% covered No deductible	Fee Schedule No deductible	100% covered No deductible	Fee Schedule No deductible
• Oral evaluations, x-rays • Cleanings • Sealants and fluoride • Space maintainers	Space maintainers are covered under Minor Restorative for Basic Plan			
Minor Restorative	80% covered	Fee Schedule	Fee Schedule	Fee Schedule
• Emergency palliative pain treatment • Amalgam restorations (fillings) • Composite restoration (fillings) • Simple extractions • Space maintainers • Pin retention	Simple extractions are not covered under Basic Plan		Space maintainers are covered under Diagnostic and Preventive for Essential Plans	
Oral Surgery	Not Covered	Not Covered	Fee Schedule	Fee Schedule
• Removal of impacted teeth • General aesthesia				
Endodontic Services	Not Covered	Not Covered	Fee Schedule	Fee Schedule
• Root Canal Therapy • Therapeutic pulpotomy • Direct pulp capping				
Periodontal Services	Not Covered	Not Covered	Fee Schedule	Fee Schedule
• Scaling and root planing • Gingivectomy • Osseous surgery • Soft tissue grafts				
Prosthodontic Services	Not Covered	Not Covered	Fee Schedule	Fee Schedule
• Crowns • Removable complete and partial dentures • Post and core • Bridge repair				
Orthodontic Services	Not Covered	Not Covered	Not Covered	Not Covered

Age Band	Dental Blue Basic 100 Rates	Dental Blue Essential 100 Rates	Dental Blue Essential 200 Rates
Adult (19-65)	$19.00	$22.50	$30.50
Child (0-18)	$13.50	$16.00	$21.50

Your Fee Schedule is included in your Individual Dental Contract. This is a summary of Dental Blue benefits. For complete benefit details, please refer to your Individual Dental Contract.

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Anthem

Choosing a dentist. You have the freedom to visit any dental provider. However, your Dentist choice can make a difference in the amount you pay. The choice is yours!

Dental Blue Basic 100 and Dental Blue Essential 100 – Using a dentist in the 100 network will be your most cost effective option. If you choose a dentist in the 200 or 300 networks, you will still receive a discount on services.

Dental Blue Essential 200 – Using a dentist in the 100 or 200 networks will be your most cost effective option. If you choose a dentist in the 300 network, you will still receive a discount on services.

How to Find a Dental Blue Provider

1. Go to anthem.com and select FIND A DOCTOR
2. Select the state in which you are seeking services
3. In the PLAN drop-down box, select ONLY DENTAL BLUE 100 (if you have Dental Blue Basic 100 or Dental Blue Essential 100) or ONLY DENTAL BLUE 200 (if you have Dental Blue Essential 200)
4. Under SELECT PROVIDR TYPE, choose DENTAL BLUE 100 (if you have Dental Blue Basic 100 or Dental Blue Essential 100) or choose DENTAL BLUE 200 (if you have Dental Blue Essential 200) for maximum savings. You can broaden your search by selecting ALL DENTAL BLUE PROVIDERS.
5. Now, you may select a specialist if needed, then click NEXT
6. Enter your search criteria
7. Click VIEW RESULTS

Filing a claim. Claims should be submitted to Anthem Dental P.O. Box 9274, Oxnard CA 93031-9274.

Limitations & Exclusions

Limitations — Here is a list of some of the limitations. Please see Individual Dental Contract for full list:
Oral Evaluations. Limited to two per calendar year.
Prophylaxis or Periodontal Prophylaxis. Limited to two treatments per calendar year.
Fluoride. Fluoride treatment limited to two per calendar year children up to age 19.
X-rays. Limited to one set of full-mouth x-rays or its equivalent in a 5-year period. Periapical x-rays are limited to 4 films per year.
Bitewing X-rays. Limited to one set of up to 4 films twice per calendar year.
Sealants. Limited to children under 16 years of age for permanent unrestored first and second molars. Treatment is limited to one application per tooth per lifetime.
Space Maintainers. Limited to once per quadrant per lifetime for children up to age 16. Includes all adjustments within six months of placement.
Restorations. Limited to once per surface per tooth every 24 months.
Periodontal Scaling. Limited to once per quadrant every 24 months.
Periodontal Surgery. Limited to one time per quadrant in a 36-month period.

Root Canal Therapy. Limited to one treatment per tooth for initial treatment and one retreatment per tooth – for permanent teeth only.
Stainless Steel Crowns. Limited to primary teeth only. Once per tooth in any 5 years.
Crowns. Limited to once per tooth in any five years
Removable Complete and Partial Dentures. Limited to once in five years. Benefits are payable for either complete or immediate dentures, but not both.
General Anesthesia. Covered only when used in conjunction with covered oral surgical procedures.

Exclusions —
Please see Individual Dental Contract for full list:
For any prescribed drugs, pre-medication or analgesia including charges for nitrous oxideor any similar local anesthetic when the charge is made separately • Forocclusal guards • For bleaching of non-vital discolored teeth • For crown buildups on the same tooth as an amalgam or composite restoration that was done within the same Calendar Year • For procedures to alter, restore or maintain occlusion, change vertical dimension, and replace or stabilize tooth structure lost by attrition, abrasion, erosion or bruxism •Harmful habit appliances For services related to diagnosis or treatment related to the temporomandibular joint (TMJ)• • For implants and all adjunctive services performed in conjunction with the placement or removal of implants including but not limited to surgery, cleanings, maintenance and prosthetics placed on implants • For infection control procedures, if billed separately • For precision attachments • For prefabricated resin crown or stainless steel crown with resin window • For pulpotomy on permanent teeth • For replacement of a prosthodontic Appliance (fixed or removable) more often than once in any five-year period , whether under this contract or under any prior dental coverage• For root canal therapy on deciduous teeth • For sealants on restored teeth (occlusal surface) • For temporary/interim prosthodontia or appliances (temporary crowns, bridges, partials, dentures, etc.) • For biopsies • • For services or supplies not specifically listed in the Covered Services section of the Individual Dental Contract..

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