Dental Net® 2000 Series Plan 2700

We're Committed To Providing You With Great Dental Care Options

Dental care is an important part of your comprehensive health care coverage and well-being. Anthem Blue Cross knows being protected with dental coverage is an important safeguard for you and your family. We have been dedicated to providing you and your family with dental coverage for more than thirty years.

Diagnostic and preventive services are the key to maintaining good dental health. Dental coverage is designed to assure that you receive regular preventive care. With routine examinations, minor dental problems can be diagnosed and treated before major, more costly problems occur. Anthem Blue Cross' Dental Net plan can be instrumental in your long-term dental health.

Dental Net is a dental HMO that offers one of the most extensive networks of quality dentists in California. When you use your selected Dental Net dentist, you will receive a higher benefit level. With Dental Net there are no deductibles and no copayments for most diagnostic or preventive services, which keeps your out-of-pocket expenses to a minimum.

Simply select the office and primary dentist that is most convenient to your home or work. Your selected dental office will provide all routine dental services and arrange for any specialty care you may need. Because each eligible family member may choose his or her own dentist, you and your family will enjoy greater flexibility and freedom of choice.

Dental Net Advantages – some important advantages when using your Dental Net plan include:

- Easy to use
- Most diagnostic and preventive care at no cost to members
- No claim forms
- No deductibles or annual maximums for most dental services
- Orthodontic coverage
- Referral to specialists from your primary dentist

Your Dental Net Plan – when you enroll in Dental Net, you'll be asked to select a participating dental office and primary dentist from a statewide directory of Dental Net network dentists. With the exception of out-of-area emergency services and certain specialty services, all of your dental care needs will be provided by, or coordinated through, your selected dental office and primary dentist. After enrollment, you will receive a member ID card listing your selected participating dental office and the phone number.

Your First Visit – because preventive dental care is so important, Dental Net provides benefits at no cost for X-rays and two teeth cleanings per year. Soon after enrollment, you should call your participating dental office for an initial diagnostic examination. X-rays will usually be taken at this time to determine the overall condition of your teeth. Through routine check-ups, minor dental problems can often be diagnosed and treated before they become major problems.

We encourage you to call your participating dental office whenever you need dental care. Please note that Dental Net does not limit the number of times you can see your dentist.

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

Dental Net Benefits – there is no deductible with Dental Net, however, some procedures require a copayment that you will need to pay at the time of service. Please refer to the amount on the chart.

Continuing Coverage – as required by federal law, certain restrictions and conditions apply to the right to continue coverage and are described in your Evidence of Coverage (EOC).

Covered Services	Per Member Copay
Diagnostic	
0120 – Periodic oral evaluation	No copay
0140 – Limited oral evaluation – problem focused	No copay
0150 – Comprehensive oral examinations	No copay
0160 – Detailed and extensive oral evaluation	No copay
0170 – Re-evaluation – Limited problem focused *(not post-operative visit)*	No copay
– Office visit – *per patient per office visit in addition to patient copays*	No copay
0210 – X-rays – intraoral – *complete series (including bitewings)*	No copay
0220 – X-rays – intraoral – *periapical – first film*	No copay

Covered Services	Per Member Copay
Diagnostic (continued)	
0230 – X-rays – intraoral – *periapical – each additional film*	No copay
0240 – X-rays – intraoral – *occlusal film*	No copay
0270 – X-rays – bitewing – *single film*	No copay
0272 – X-rays – bitewings – *two films*	No copay
0274 – X-rays – bitewings – *four films*	No copay
0277 – X-rays – vertical bitewings	No copay
0330 – X-rays – panoramic film	No copay
0460 – Pulp vitality tests	No copay
0470 – Diagnostic casts	No copay
9310 – Consultation – *per session*	No copay

Covered Services	Per Member Copay
Preventive	
1110 – Prophylaxis – adult [1]	No copay
1120 – Prophylaxis – child [1]	No copay
1201 – Topical Fluoride – child *(including prophylaxis)*	No copay
1203 – Topical Fluoride – child *(excluding prophylaxis)*	No copay
1204 – Topical Fluoride – adult *(excluding prophylaxis)*	No copay
1205 – Topical Fluoride – adult *(including prophylaxis)*	No copay
1330 – Oral hygiene instructions	No copay
1351 – Sealants – *per tooth*	$10
1510 – Space maintainers – *fixed - unilateral*	$25
1515 – Space maintainers – *fixed - bilateral*	$25
1520 – Space maintainers – *removable - unilateral*	$25
1525 – Space maintainers – *removable - bilateral*	$25
1550 – Recementation of space maintainer	$5
Restorative	
2110 – Fillings, amalgams – *one surface, primary*	No copay
2120 – Fillings, amalgams – *two surfaces, primary*	No copay
2130 – Fillings, amalgams – *three surfaces, primary*	No copay
2131 – Fillings, amalgams – *four or more surfaces, primary*	No copay
2140 – Fillings, amalgams – *one surface, permanent*	No copay
2150 – Fillings, amalgams – *two surfaces, permanent*	No copay
2160 – Fillings, amalgams – *three surfaces, permanent*	No copay
2161 – Fillings, amalgams – *four or more surfaces, permanent*	No copay
2330 – Resin – *one surface, anterior*	No copay
2331 – Resin – *two surfaces, anterior*	No copay
2332 – Resin – *three surfaces, anterior*	No copay
2335 – Resin – *four or more surfaces, anterior, or involving incisal angle*	$10
2391 – Resin – *based composite, one surface, posterior – primary*	*$30*
2391 – Resin – *based composite, two surfaces, posterior – permanent*	*$50*
2392 – Resin – *based composite, three surfaces, posterior – primary*	*$40*
2392 – Resin – *based composite, four or more surfaces, posterior – permanent*	*$65*
2393 – Resin – *based composite, one surface, posterior – primary*	*$50*
2393 – Resin – *based composite, two surfaces, posterior – permanent*	*$75*
2394 – Resin – *based composite, four or more surfaces, posterior*	*$85*
Endodontics	
3110 – Pulp cap – *Direct (excluding final restoration)*	No copay
3120 – Pulp cap – *Indirect (excluding final restoration)*	No copay
3220 – Therapeutic pulpotomy *(excluding final restoration)*	$5

[1] For the third cleaning in a 12 month period, the copay is 80% of the dentist's usual fee.

[2] Independent procedures copays cannot be combined.

[3] Histopathological exam is not included and is not benefited.

[4] In preparation for dentures.

[5] Plus actual costs for noble/high (precious) metal not to exceed $100.

Covered Services	Per Member Copay
Endodontics (continued)	
3221 – Gross pulp debridement *primary & permanent teeth*	$15
3310 – Anterior root canal therapy – *1 canal (excluding final restoration)*	$75
3320 – Bicuspid root canal therapy – *2 canals (excluding final restoration)*	$125
3330 – Molar root canal therapy – *3 canals (excluding final restoration)*	$180
3332 – Incomplete endodontic therapy *(inoperable or fractured tooth)*	$45
3346 – Retreatment of previous anterior root canal therapy	$85
3347 – Retreatment of previous bicuspid root canal therapy	$130
3348 – Retreatment of previous molar root canal therapy	$150
3410 – Apicoectomy/periradicular surgery – *anterior*	$90
3421 – Apicoectomy/periradicular surgery – *bicuspid (first root)*	$90
3425 – Apicoectomy/periradicular surgery – *molar (first root)*	$90
3426 – Apicoectomy/periradicular surgery – *each additional tooth*	$90
3430 – Retrograde filling – *per root*	$75
3910 – Surgical procedure for isolation of tooth with rubber dam	No copay
3950 – Canal preparation and fitting of preformed dowel or post	No copay
Periodontics	
4210 – Gingivectomy/Gingivoplasty – *per quadrant*	$75
4211 – Gingivectomy/Gingivoplasty – *per tooth*	$20
4220 – Gingival curettage, surgical – *per quadrant*	$15
4260 – Osseous surgery – four or more contiguous, *per quadrant*	$200
4261 – Osseous surgery – one to three contiguous, *per quadrant*	$200
4341 – Periodontal scaling/root planing – four or more teeth, *per quadrant*	$25
4342 – Periodontal scaling/root planing – one to three teeth, *per quadrant*	$25
4355 – Full mouth debridement to enable comprehensive periodontal evaluation/diagnosis	$25
4910 – Periodontal maintenance procedures *(following active therapy)*	$30
Oral Surgery	
7110 – Single extraction/each	No copay
7111 – Extraction, coronal remnants – deciduous tooth	No copay
7120 – Additional tooth	No copay
7130 – Root removal – *exposed roots*	No copay
7140 – Extraction, erupted tooth or exposed roots	No copay
7210 – Surgical removal of erupted tooth	$25
7220 – Removal of impacted tooth – *soft tissue*	$30
7230 – Removal of impacted tooth – *partial bony*	$75
7240 – Removal of impacted tooth – *completely bony* [2]	$85
7241 – Removal of impacted tooth – *completely bony, with unusual surgical* [2]	$85
7250 – Surgical removal of residual tooth roots *(cutting procedure)*	$55
7285 – Biopsy of oral tissue – *hard (bone, tooth)* [3]	$20
7286 – Biopsy of oral tissue – *soft (all others)* [3]	$20
7310 – Alveoloplasty in preparation for dentures, with extractions – *per quadrant* [4]	$65
7320 – Alveoloplasty in preparation for dentures, without extractions – *per quadrant* [4]	$80
7510 – Incision & drainage of abscess – *Intraoral soft tissue*	$25

Covered Services	Per Member Copay
Prosthodontics	
2510 – Inlay – metallic – *one surface* [5]	$65
2520/6520 – Inlay – metallic – *two surfaces* [5]	$75
2530/6530 – Inlay – metallic – *three or more surfaces* [5]	$85
2542 – Onlay – metallic – *two surfaces* [5]	$125
2543/6543 – Onlay – metallic – *three surfaces* [1]	$125
2544/6544 – Onlay – metallic – *four or more surfaces* [1]	$125
2740 – Crown – porcelain/ceramic substrate	$200
2750 – Crown – porcelain fused to high noble metal [1]	$100
2751 – Crown – porcelain fused to predominantly base metal	$100
2752 – Crown – porcelain fused to noble metal [1]	$100
2780 – Crown – cast high noble metal [1]	$100
2781 – Crown – cast high predominantly base metal	$100
2782 – Crown – cast noble metal [1]	$100
2783 – Crown – porcelain/ceramic	$100
2790 – Crown – Full cast high noble metal [1]	$100
2791 – Crown – Full cast predominantly base metal	$100
2792 – Crown – Full cast noble metal [1]	$100
2810 – Crown – cast metallic [1]	$100
2910 – Recement inlay	No copay
2920 – Recement crown	No copay
2930/ – Prefabricated stainless steel crown	No copay
2931 – *primary/permanent tooth (provisional)*	
2932 – Prefabricated resin crown *(provisional)*	$10
2940 – Sedative filling	No copay
2950 – Core buildup, *including any pins*	$15
2951 – Pin retention – *per tooth, in addition to restoration*	$10
2952 – Cast post and core *in addition to crown*	$35
2953 – Each additional cast post *(same tooth)*	No copay
2954 – Prefabricated post and core *in addition to crown*	$35
2955 – Post removal (*not in conjunction with endodontic therapy)*	$10
2957 – Each additional prefab post *(same tooth)*	No copay
2970 – Temporary crown *(fractured tooth)*	$15
6210 – Pontic – Cast high noble metal [1]	$100
6211 – Pontic – Cast predominantly base metal	$100
6212 – Pontic – Cast noble metal [1]	$100
6240 – Pontic – Porcelain fused to high noble metal [1]	$100
6241 – Pontic – Porcelain fused to predominantly base metal	$100
6242 – Pontic – Porcelain fused to noble metal [1]	$100
6245 – Pontic – Porcelain/ceramic	$100
6604 – Inlay – Cast predominantly base metal, two surfaces[1]	$75
6605 – Inlay – Cast predominantly base metal, three or more surfaces[1]	$85
6612 – Onlay – Cast predominantly base metal, two surfaces[1]	$125
6613 – Onlay – Cast predominantly base metal, three or more surfaces[1]	$125
6740 – Crown – Porcelain/ceramic	$100
6750 – Crown – porcelain fused to high noble metal [1]	$100
6751 – Crown – porcelain fused to predominantly base metal	$100
6752 – Crown – porcelain fused to noble metal [1]	$100
6780 – Crown – cast high noble metal [1]	$100
6781 – Crown – cast high predominantly base metal	$100
6782 – Crown – cast noble metal [1]	$100
6783 – Crown – porcelain/ceramic	$100
6790 – Crown – Full cast high noble metal [1]	$100
6791 – Crown – Full cast predominantly base metal	$100
6792 – Crown – Full cast noble metal	$100
6930 – Recement fixed partial denture	$5
6970 – Cast post and core *in addition to fixed partial denture retainer*	$35

[1] Plus actual costs for noble/high (precious) metal not to exceed $100.

[2] Either type of denture is an acceptable restoration; however, Dental Net benefits the first one placed, not both.

[3] Not prescription drugs.

Covered Services	Per Member Copay
Prosthodontics (continued)	
6971 – Cast post *as part of fixed, partial denture retainer*	$35
6972 – Prefabricated post and core *in addition to fixed partial denture retainer*	$35
6973 – Core buildup for retainer, *including any pins*	$15
6976 – Each additional cast post *(same tooth)*	No copay
6977 – Each additional prefab post *(same tooth)*	No copay
5110/ – Complete denture [2]	$150
5120 *(maxillary/mandibular)*	
5130/ – Immediate denture [2]	$150
5140 *(maxillary/mandibular)*	
5211/ – Partial denture *(maxillary/mandibular)*	$175
5212 – *resin base (including clasps, rests)*	
5213/ – Partial denture *(maxillary/mandibular)*	$200
5214 – *cast metal framework with resin denture bases*	
5410/ – Adjust complete denture	$15
5411 *(maxillary/mandibular)*	
5421/ – Adjust partial denture	$15
5422 *(maxillary/mandibular)*	
5510 – Repair broken complete denture base	$25
5520 – Replace missing or broken teeth – *complete denture (each tooth)*	$25
5610 – Repair resin denture base	$25
5620 – Repair cast framework	$25
5630 – Repair or replace broken clasp	$25
5640 – Replace broken teeth – *(per tooth)*	$15
5650 – Add tooth to existing partial denture	$15
5660 – Add clasp to existing partial denture	$30
5710/ – Rebase complete denture	
5711 *(maxillary/mandibular)*	$80
5720/ – Rebase partial denture	$80
5721 *(maxillary/mandibular)*	
5730/– Complete denture reline – chairside	$25
5731 *(maxillary/mandibular)*	
5740/ – Partial denture reline – chairside	$25
5741 *(maxillary/mandibular)*	
5750/ – Complete denture reline – laboratory	$50
5751 *(maxillary/mandibular)*	
5760/ – Partial denture reline – laboratory	$50
5761 *(maxillary/mandibular)*	
5820/ – Interim partial denture	$100
5821 *(maxillary/mandibular)*	
5850 – Tissue conditioning – *per denture*	$25
5851 – Tissue conditioning – lower – *per denture*	$25
Other Services	
Out-of-area emergency *(limited to $50 benefit)*	No copay; all charges over $50
9110 – Palliative emergency treatment of dental pain – *minor procedure*	$5
9211 – Regional block anesthesia	No copay
9215 – Local anesthesia	No copay
9310 – Consultation	No copay
9430 – Office visits for observation *(during regularly scheduled hours)*	No copay
9440 – Office visits – after hours	$45
9630 – Other drugs and/or medicaments, *(by report)* [3]	$15
– Broken appointments *(less than 24 hours)*	$25
Orthodontics	
24 months of usual and customary *exclusive of records and retention fees*	
8080 – Child through age 17	$1,450
8090 – Adult age 18 and over	$1,450
8660 – Pre-orthodontic visits and treatment plan	$300
8680 – Orthodontic retention	$275

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive the Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

Dental Net 2000 Series Exclusions & Limitations

LIMITED SERVICES

Unauthorized Services. Dental services must be received from the member's participating dental office unless an exception is specifically authorized in writing by the member's participating dental office and/or Dental Net.

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

Prophylaxis. Procedures are limited to two treatments during each calendar year. If a third prophylaxis is provided within the calendar year, it will be subject to a 80% copayment based on the participating dentist's usual fee.

Periodontal Procedures. Periodontal scaling and root planing and/or gingival curettage are limited to one course of therapy per quadrant during any 12-month period. Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis is limited to one course of treatment per lifetime.

Prosthodontic Replacements. Partial dentures are not eligible for replacement within five years of original placement unless required as a result of additional tooth loss which cannot be restored by modification of the existing partial denture. Crowns, bridges, inlays and/or complete dentures are not eligible for replacement within five years of original placement.

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

Denture Relines. Complete and/or partial denture relines or rebases are limited to one per denture during any 12-month period.

Precious Metals. The use of alloys with 25% or more noble metal content for any restorative procedure is considered optional and, if used, the additional cost for such alloy should not exceed $100 and will be the member's responsibility.

Impactions. Removal of impacted teeth is limited to impactions which show radiographic evidence of a pathologic condition or for which the member experiences unresolved symptoms of infection, swelling or chronic pain.

Pediatric Annual Maximum. Pediatric dental services are limited to $500 per calendar year for each child. Referral to a pedodontist will be considered for children to the age of 5. Charges in excess of $500 will be the member's financial responsibility.

Porcelain on molars. If porcelain to metal crowns are placed on molars, an additional charge of $75 per tooth will be charged.

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.

SERVICES NOT COVERED

Not Acceptable Services. Any service or supply which we determine not to be an acceptable service, as specified in the Evidence of Coverage (EOC).

Cosmetic Services. Dental services necessary solely for cosmetic reasons including, but not limited to, bleaching of non-vital discolored teeth, veneers and all other cosmetic procedures (unless specifically shown as a covered benefit).

Workers' Compensation. Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, under any workers' compensation or occupational disease law, even if the member does not claim those benefits.

Government Programs. Care or treatment which is obtained from or for which payment is made by any federal, state, county, municipal or other government agency, including any foreign government.

Fractures or Dislocations. Treatment of jaw fractures or dislocations.

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 any dental treatment, which because of the member's general health or mental, emotional, behavioral, or physical limitations, cannot be performed in the participating dental office.

Lost or Stolen Dentures or Appliances. Replacement of lost crowns, lost or stolen dentures, bridgework or other dental appliances.

Services Provided Before or After the Term of the Member's Coverage. Dental treatment or expenses incurred in connection with any dental procedure started prior to the member's effective date. Dental treatment or expenses incurred after termination of the member's coverage, as specified as covered in the Evidence of Coverage (EOC).

Treatment by a Non-Participating Dentist. Any corrective treatment required as a result of dental services performed by a non-participating dentist while this coverage is in effect, and any dental services started by a non-participating dentist will not be the responsibility of the participating dental office or Dental Net for completion.

Cysts and Neoplasms. Histopathological exams and/or the removal of tumors, cysts, neoplasms and foreign bodies.

Congenital (Hereditary) or Developmental Malformations. Dental treatment or expenses incurred in connection with the correction of congenital or developmental malformations including, but not limited to, enamel hypoplasia, fluorosis, anodontia, supernumary 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. Inlays, onlays, crowns, fixed bridges, or removable cast partials for members under 16 years of age. Space maintainers for members over age sixteen.

Experimental or Investigative Procedures. Procedures which are considered experimental or investigative or which are not widely accepted as proven and effective procedures within the organized dental community.

Implants. Dental procedures and charges incurred as part of implants or the removal of same. Fixed or removable prosthetics in conjunction with implants. Prophylaxis on implants.

Vertical Dimension and Attrition. Dental treatment or procedures (other than those for replacement of structure lost due to dental decay) required in conjunction with opening a bite or replacing tooth structure lost by wear, erosion or abrasion or due to bruxism. (Does not apply to alteration by removable prosthodontics.)

Periodontal Splinting. Dental treatment or expenses incurred in connection with periodontal splinting.

Treatment of the Joint of the Jaw. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues.

General Anesthesia. General anesthesia, inhalation sedation, intravenous sedation or intramuscular sedation.

Procedures Not Specified as Covered. Any procedure not specifically listed as a covered service.

Drugs or Dispensing of Drugs. Plan does not cover prescription drugs as a dental benefit.

Questionable, Guarded or Poor Prognosis. Teeth with questionable, guarded or poor prognosis are not covered for endodontic treatment, periodontal surgery or crown and bridge. Dental Net will allow for observation or extraction and prosthetic replacement.

Personalization, Characterization or Precision Attachments. Precision attachments, characterization or personalization of dentures is excluded.

Crown Lengthening. Crown exposure, ligation and crown lengthening are not covered.

Removal of Third Molars. Immature erupting third molars are not covered for extraction, i.e., tooth proceeding through a normal eruption process.

Primary Restorations. Gold, porcelain or resin fillings on primary teeth are excluded.

Denture Replacement. Dentures, full or partial-replacements will be made only if existing denture is five (5) years old, is unsatisfactory and cannot be made serviceable.

ORTHODONTIC EXCLUSIONS AND LIMITATIONS

ORTHODONTIC LIMITATIONS

Authorized Orthodontic Services. Orthodontic services must be received from the member's participating orthodontic office as specifically authorized and referred by Dental Net in writing.

Lifetime Maximum. Orthodontic treatment is limited to one full case (up to 24 months of standard orthodontic care) during the member's lifetime.

Loss of Coverage During Orthodontic Treatment. If the member's coverage under the plan ends, for any reason, while the member is still receiving orthodontic treatment during the 24 month treatment period, the member and NOT Dental Net will be responsible for the remainder of the cost for that treatment, at the contracted fee for the remaining number of months of treatment.

Orthodontic consultation/Observation Fees. If treatment is not required or the member chooses not to start treatment after a diagnosis and consultation have been completed by the provider, the member may be charged a consultation fee of $30 in addition to diagnostic record fees.

Orthodontic Retention Phase of Care. Retention services include initial fabrication, placement, observation, and adjustments of passive retention appliances for a 12-month period. The retention services fee of $275 is the member's responsibility and is payable at the beginning of the retention phase of treatment. Retention services fees are subject to review and modification on an annual basis.

Orthodontic Services in Excess of 24 Months of Active Care. The member is required to pay the participating orthodontist of $55 per month for each additional month of standard active orthodontic treatment provided beyond the 24 month period, but before the retention phase of treatment begins.

ORTHODONTIC EXCLUSIONS

Changes in Treatment. Changes in treatment necessitated by an accident of any kind or patient noncompliance.

Myofunctional Therapy. Myofunctional therapy and related services. (Myofunctional therapy involves the use of muscle exercises as an adjunct to orthodontic mechanical correction of malocclusion.)

Orthodontic Retreatment. The retreatment of a previously treated orthodontic case (whether treated under this coverage, at fee-for-service, or under another benefit plan) is not covered.

Services Provided Before or After the Term of This Coverage. Orthodontic treatment begun prior to the member's effective date or after the termination of coverage.

Other Orthodontic Services. Services for braces, other orthodontic appliances, or orthodontic services, except as specifically stated in this coverage.

Orthodontic Treatment Incidental to Surgical Procedures. Orthodontic treatment in conjunction with oral surgical procedures including, but not limited to, orthognatic surgery.

Phase I Orthodontics/Orthopaedic/Orthodontic Treatment. Any Phase I treatment or orthopaedic/orthodontic treatment which may be deemed advantageous or necessary by the participating orthodontist prior to the 24 months or standard active treatment. Orthodontic treatment for malocclusions which, in the opinion of the participating orthodontist will not produce beneficial results.

Replacement of Orthodontic Appliances. Replacement of lost or stolen orthodontic appliances or repair of orthodontic appliances broken due to the member's negligence.

Special Orthodontic Appliances. Special types of orthodontic appliances which are considered cosmetic including, but not limited to, lingual or "invisible" braces, sapphire or clear braces, or ceramic braces.

Surgical Procedures Incidental to Orthodontic Treatment. Surgical procedures incidental to orthodontic treatment including, but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, ligation, correction of micrognathia or macrognathia, or repair of cleft palate.

T.M.J. or Hormonal Imbalance Orthodontic Services. Treatment related to the joint of the jaw (temporomandibular joint, TMJ) and/or hormonal imbalance.

Third Party Liability. Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

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