



# Anthem Extras Packages

Dental, Vision and more

California

# Benefits that complement your Medicare Supplement plan

## Packaged benefits — better together

Healthy teeth and eyes help contribute to your overall well-being. That's why Anthem Blue Cross (Anthem) created Anthem Extras Packages – with your overall health in mind. We offer three packages to complement your Medicare Supplement plan – and help you reach for better health. Our Standard, Premium and Premium Plus packages offer valuable benefits and services, such as:

- › Packaged dental and vision coverage that offers extra preventive benefits
- › Support services and tools to help you maintain good overall health and well-being

And best of all, these packages are available for a monthly plan premium ranging from **\$25** to **\$61**. The benefits in each package will roll up to one overall premium, and you will receive one ID card for these services.

## Interested in dental coverage only?

Good news. Our Dental Policy Only offers the same dental benefits as the Premium Plus Package on a stand-alone basis without the other package components.

## Dental coverage

It's important to have dental benefits that can help you look after your overall health, such as:

- › Coverage for diagnostic and preventive care – which can be key to good long-term oral health
- › Third cleaning or periodontal maintenance procedures covered for diabetic members on all of our Anthem Extras Packages plans

And, for your convenience, you'll have:

- › Access to more than 12,000 unique dentists with more than 29,000 access points in California, and more than 87,000 access points nationwide
- › Freedom from paperwork – network dentists file claims, and there are no referrals needed

Plus, you will automatically have access to the International Emergency Dental Program administered by DeCare Dental, a wholly owned subsidiary of the parent company of Anthem Blue Cross. With this feature, you have access to emergency dental care while traveling nearly anywhere in the world from our listing of credentialed dentists.

## Is your dentist in the network?

To see if your dentist is in our current network, visit our website, **[www.anthem.com/ca](http://www.anthem.com/ca)**. When prompted, choose the Dental Blue 100 network.

If you prefer, you can contact our customer service center at **1-877-391-3897** (8 a.m. – 5 p.m. local time) for assistance.

## You might pay more when you visit an out-of-network dentist

Your plan lets you choose any dentist, whether or not that dentist is part of our network. But you may end up paying more for a service if you visit an out-of-network dentist.

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



Here’s an example of how using in-network dental services can lower your costs

This is an example only. Your experience may be different depending on your insurance plan, the services you get and who provides the services.

Ted gets a crown from an out-of-network dentist who charges \$1,200 for the service and bills Anthem for that amount.

Anthem’s maximum allowed amount for this dental service is \$800. That means there will be a \$400 difference, which the dentist can balance bill Ted.

Since Ted will also need to pay \$400 coinsurance, the total he’ll pay the out-of-network dentist is \$800.

Here’s the math:

- › Dentist’s charge: \$1,200
- › Anthem’s maximum allowed amount: \$800
- › Anthem pays 50%: \$400
- › You pay 50% (coinsurance): \$400
- › Balance you owe the provider: \$1,200 - \$800 = \$400
- › Your total cost:  
**\$400 coinsurance + \$400 provider balance = \$800**

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

Vision coverage

Regular eye exams can often help detect early on some major health conditions, like diabetes and cardiovascular disease. And early detection can mean lower health care costs, and – most importantly – a healthier you! That’s why our vision plans include:

- › Access to a broad, convenient, network of more than 50,000 independently contracted vision providers and provider locations across the country
- › That’s why our vision plans include a network comprised mainly of independent optometrists and ophthalmologists. But for added convenience, our vision network also includes national retail locations such as LensCrafters®, Sears Optical<sup>SM</sup>, Target Optical® and JCPenney® Optical
- › Prescription eyewear that is delivered quickly – in as little as an hour in some retail locations

Benefits vary by package, but all packages include eye exams, as well as allowances for eyeglass frames and lenses or contact lenses.

Save even more

Even after benefits have been exhausted, additional savings are offered for noncovered materials such as extra pairs of eyewear, a number of nonprescription sunglasses and other popular accessories. You can save 15%-40% by taking advantage of this unique option. And to add even more value, there is no limit to the number of purchases you can make using the additional savings program.

Easy-to-use benefits

Your out-of-pocket expenses may be lower, and you can avoid paperwork hassles when you visit network vision providers. In-network providers verify your benefits and get the information they need to file claims for you. All you need to do is:

- › Make an appointment with an in-network provider
- › Present your ID card at the time of service
- › Pay any applicable copays and any balance for noncovered services

Here when you need us

We are committed to providing excellent customer service. In fact, our customer service hours are among the longest in the industry. We provide customer service seven days a week, and you’ll speak with well-trained representatives dedicated to your vision benefit support.

Find a vision provider in the network

To see if your vision provider is in our current network, visit our website, [www.anthem.com/ca](http://www.anthem.com/ca). When prompted, choose the Blue View Vision network.

Travel assistance

What would happen if you got sick in another country? Who would you call if you couldn’t speak the native language? With travel assistance, you’ll get extended service 24 hours a day, seven days a week, no matter where life takes you.

If you have an emergency medical situation while traveling abroad, simply call our assistance coordination line from any country to:

- › Coordinate and pay for medical evacuation to the nearest appropriate treatment facility or back home when medically necessary
- › Schedule a bedside visit for a family member or friend if you are hospitalized for more than seven days, or if you are in critical condition
- › Access health-related travel planning information and receive assistance in replacing lost prescription medications, eyeglasses or contact lenses while traveling

Additional services available.



SilverSneakers®  
Fitness Program

HEALTHWAYS  
SilverSneakers®  
FITNESS

It's easy and affordable for you to get fit, have fun and make friends using a SilverSneakers fitness membership. With SilverSneakers you have:

- Access to more than 11,000 participating locations across the country
- All basic amenities such as exercise equipment and SilverSneakers fitness classes
- SilverSneakers Online, an easy-to-use wellness resource
- SilverSneakers Steps for members who don't have convenient access to a SilverSneakers location

To request your SilverSneakers ID number and closest location, simply call **1-888-423-4632** (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. ET. Take your ID number with you when you visit your location.

Please consult with your physician before starting a physical activity program.

Included in our Medicare Supplement plans

If you enroll in a Medicare Supplement plan with Anthem, SilverSneakers may be a part of that plan. Anthem Medicare Supplement plan members can choose an Anthem Extras Package without this added benefit.



## Dental

Below is an overview of the dental plans available. See what fits your lifestyle best and enroll today.

|                                                                                                 | Standard Package                                                                                                                                                                                                         | Premium Package                                                                                                                                                                                                          | Premium Plus Package                                                                                                                                                                                                     | Dental Policy Only                                                                                                                                                                                                       |
|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                 | In- or Out-of-Network                                                                                                                                                                                                    | In- or Out-of-Network                                                                                                                                                                                                    | In- or Out-of-Network                                                                                                                                                                                                    | In- or Out-of-Network                                                                                                                                                                                                    |
| Annual Maximum (the maximum amount Anthem will pay per calendar year)                           | \$500 per member per benefit year                                                                                                                                                                                        | \$1,000 per member per benefit year                                                                                                                                                                                      | \$1,250 per member per benefit year                                                                                                                                                                                      | \$1,250 per member per benefit year                                                                                                                                                                                      |
| Annual Deductible (the amount you will pay before we begin to pay for certain covered services) | No deductible                                                                                                                                                                                                            | \$50 per member per benefit year. The deductible does not apply to diagnostic and preventive services for in-network and out-of-network.                                                                                 | \$50 per member per benefit year. The deductible does not apply to diagnostic and preventive services for in-network and out-of-network.                                                                                 | \$50 per member per benefit year. The deductible does not apply to diagnostic and preventive services for in-network and out-of-network.                                                                                 |
| Network                                                                                         | Dental Blue 100 Network                                                                                                                                                                                                  | Dental Blue 100 Network                                                                                                                                                                                                  | Dental Blue 100 Network                                                                                                                                                                                                  | Dental Blue 100 Network                                                                                                                                                                                                  |
| Diagnostic and Preventive Services (routine cleanings, exams and X-rays)                        | 100% covered when using a participating dentist<br><br>Limited to 2 routine cleanings (including periodontal maintenance), 2 exams and 1 set of bitewing X-rays per year<br><br>Complete X-ray series once every 5 years | 100% covered when using a participating dentist<br><br>Limited to 2 routine cleanings (including periodontal maintenance), 2 exams and 1 set of bitewing X-rays per year<br><br>Complete X-ray series once every 5 years | 100% covered when using a participating dentist<br><br>Limited to 2 routine cleanings (including periodontal maintenance), 2 exams and 1 set of bitewing X-rays per year<br><br>Complete X-ray series once every 5 years | 100% covered when using a participating dentist<br><br>Limited to 2 routine cleanings (including periodontal maintenance), 2 exams and 1 set of bitewing X-rays per year<br><br>Complete X-ray series once every 5 years |
| Minor Restorative Dental Services (fillings)                                                    | Not covered                                                                                                                                                                                                              | Covered at 80% (you pay 20%) after a 6-month waiting period                                                                                                                                                              | Covered at 80% (you pay 20%) after a 6-month waiting period                                                                                                                                                              | Covered at 80% (you pay 20%) after a 6-month waiting period                                                                                                                                                              |
| Periodontal Services (scaling and root planing)                                                 | Not covered                                                                                                                                                                                                              | Covered at 50% (you pay 50%) after a 12-month waiting period                                                                                                                                                             | Covered at 50% (you pay 50%) after a 12-month waiting period                                                                                                                                                             | Covered at 50% (you pay 50%) after a 12-month waiting period                                                                                                                                                             |
| Endodontics (root canals) and Oral Surgery (simple tooth extractions)                           | Not covered                                                                                                                                                                                                              | Covered at 50% (you pay 50%) after a 12-month waiting period                                                                                                                                                             | Covered at 50% (you pay 50%) after a 12-month waiting period                                                                                                                                                             | Covered at 50% (you pay 50%) after a 12-month waiting period                                                                                                                                                             |
| Prosthodontics (crowns, dentures and bridges)                                                   | Not covered                                                                                                                                                                                                              | Not covered                                                                                                                                                                                                              | Covered at 50% (you pay 50%) after a 12-month waiting period                                                                                                                                                             | Covered at 50% (you pay 50%) after a 12-month waiting period                                                                                                                                                             |

For additional dental limitations and exclusions, please refer to your dental policy received upon enrollment.

Vision

There are several vision plans to choose from. Find the deductible and benefits that best fit your needs and enroll today.



|                                                                                                                                         | Standard Package                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                            | Premium Package                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                            | Premium Plus Package                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                         | In-Network Benefit                                                                                                                                                                                                                  | Out-of-Network Reimbursement Benefit                                                                                                                                                                                                                                       | In-Network Benefit                                                                                                                                                                                                                  | Out-of-Network Reimbursement Benefit                                                                                                                                                                                                                                       | In-Network Benefit                                                                                                                                                                                                                 | Out-of-Network Reimbursement Benefit                                                                                                                                                                                                                                       |
| <b>Vision Examination</b><br>Covered up to a comprehensive level exam with dilation as necessary                                        | \$20 copayment<br>(You pay a \$20 copayment when you receive this service from an in-network provider. Allowed once every 12 months.)                                                                                               | You pay amount in excess of \$30.<br>(Anthem will pay up to \$30 toward this service if you visit an out-of-network provider. You will need to pay the full costs at the time of your visit and submit a claim to be reimbursed up to \$30. Allowed once every 12 months.) | \$20 copayment<br>(You pay a \$20 copayment when you receive this service from an in-network provider. Allowed once every 12 months.)                                                                                               | You pay amount in excess of \$30.<br>(Anthem will pay up to \$30 toward this service if you visit an out-of-network provider. You will need to pay the full costs at the time of your visit and submit a claim to be reimbursed up to \$30. Allowed once every 12 months.) | \$10 copayment<br>(You pay a \$10 copayment when you receive this service from an in-network provider. Allowed once every 12 months.)                                                                                              | You pay amount in excess of \$30.<br>(Anthem will pay up to \$30 toward this service if you visit an out-of-network provider. You will need to pay the full costs at the time of your visit and submit a claim to be reimbursed up to \$30. Allowed once every 12 months.) |
| <b>Eyeglass Frames</b><br>Once every 24 months<br>You may select an eyeglass frame and receive the allowance toward the purchase price. | You pay amount in excess of \$100. A 20% discount applies to the balance over the Policy allowance.<br>(Anthem will pay \$100 toward your eyeglass frames, then you will also receive an additional 20% off any remaining balance.) | You pay amount in excess of \$45.<br>(Anthem will pay up to \$45 toward your eyeglass frames. You will need to pay the full costs at the time of your visit and submit a claim to be reimbursed.)                                                                          | You pay amount in excess of \$100. A 20% discount applies to the balance over the Policy allowance.<br>(Anthem will pay \$100 toward your eyeglass frames, then you will also receive an additional 20% off any remaining balance.) | You pay amount in excess of \$45.<br>(Anthem will pay \$45 toward your eyeglass frames. You will need to pay the full costs at the time of your visit and submit a claim to be reimbursed.)                                                                                | You pay amount in excess of \$130. A 20% discount applies to the balance over the Policy allowance.<br>(Anthem will pay \$130 toward your eyeglass frames then you will also receive an additional 20% off any remaining balance.) | You pay amount in excess of \$45.<br>(Anthem will pay up to \$45 toward your eyeglass frames. You will need to pay the full costs at the time of your visit and submit a claim to be reimbursed.)                                                                          |

For additional vision limitations and exclusions, please refer to your vision policy received upon enrollment. Discounts are subject to change without notice.

Vision (continued)

|                                                                                                                                                                                                                                                                                                                                                                                         | Standard Package                                  |                                                                                                                                            | Premium Package                                   |                                                                                                                                            | Premium Plus Package                              |                                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                         | In-Network Benefit                                | Out-of-Network Reimbursement Benefit<br>You will need to pay the full costs at the time of your visit and submit a claim to be reimbursed. | In-Network Benefit                                | Out-of-Network Reimbursement Benefit<br>You will need to pay the full costs at the time of your visit and submit a claim to be reimbursed. | In-Network Benefit                                | Out-of-Network Reimbursement Benefit<br>You will need to pay the full costs at the time of your visit and submit a claim to be reimbursed. |
| <b>Eyeglass Lenses</b> (Standard) Once every 24 months you may receive 1 set of lenses.                                                                                                                                                                                                                                                                                                 |                                                   |                                                                                                                                            |                                                   |                                                                                                                                            |                                                   |                                                                                                                                            |
| Standard plastic single vision lenses (1 pair)                                                                                                                                                                                                                                                                                                                                          | \$20 copayment                                    | Up to \$25 allowance                                                                                                                       | \$20 copayment                                    | Up to \$25 allowance                                                                                                                       | \$10 copayment                                    | Up to \$25 allowance                                                                                                                       |
| Standard plastic bifocal lenses (1 pair)                                                                                                                                                                                                                                                                                                                                                | \$20 copayment                                    | Up to \$40 allowance                                                                                                                       | \$20 copayment                                    | Up to \$40 allowance                                                                                                                       | \$10 copayment                                    | Up to \$40 allowance                                                                                                                       |
| Standard plastic trifocal lenses (1 pair)                                                                                                                                                                                                                                                                                                                                               | \$20 copayment                                    | Up to \$55 allowance                                                                                                                       | \$20 copayment                                    | Up to \$55 allowance                                                                                                                       | \$10 copayment                                    | Up to \$55 allowance                                                                                                                       |
| <b>Contact Lenses</b><br>You may choose to receive contact lenses instead of eyeglass lenses. You will receive an allowance toward the cost of a supply of contact lenses every 24 months. Your contact lenses allowance must be used at the time of initial service. No remaining allowance may be carried forward to subsequent materials in the same or the following calendar year. |                                                   |                                                                                                                                            |                                                   |                                                                                                                                            |                                                   |                                                                                                                                            |
| Elective Conventional Contact Lenses                                                                                                                                                                                                                                                                                                                                                    | \$80 allowance then 15% off the remaining balance | Up to \$60 allowance                                                                                                                       | \$80 allowance then 15% off the remaining balance | Up to \$60 allowance                                                                                                                       | \$80 allowance then 15% off the remaining balance | Up to \$60 allowance                                                                                                                       |
| Elective Disposable Contact Lenses                                                                                                                                                                                                                                                                                                                                                      | \$80 allowance (no additional discount)           | Up to \$60 allowance                                                                                                                       | \$80 allowance (no additional discount)           | Up to \$60 allowance                                                                                                                       | \$80 allowance (no additional discount)           | Up to \$60 allowance                                                                                                                       |
| Non-Elective Contact Lenses                                                                                                                                                                                                                                                                                                                                                             | Covered in full                                   | Up to \$210 allowance                                                                                                                      | Covered in full                                   | Up to \$210 allowance                                                                                                                      | Covered in full                                   | Up to \$210 allowance                                                                                                                      |
| <b>Contact Lenses Fitting and Follow-up</b><br>A contact lenses fitting and 2 follow-up visits are available to you once a comprehensive eye exam has been completed.                                                                                                                                                                                                                   |                                                   |                                                                                                                                            |                                                   |                                                                                                                                            |                                                   |                                                                                                                                            |
| Standard Contact Fitting*                                                                                                                                                                                                                                                                                                                                                               | Up to \$55                                        | Not covered                                                                                                                                | Up to \$55                                        | Not covered                                                                                                                                | Up to \$55                                        | Not covered                                                                                                                                |
| Premium Contact Fitting**                                                                                                                                                                                                                                                                                                                                                               | 10% off retail price                              | Not covered                                                                                                                                | 10% off retail price                              | Not covered                                                                                                                                | 10% off retail price                              | Not covered                                                                                                                                |

\*A standard contact lenses fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include, but are not limited to, disposable and frequent replacement.

\*\* A premium contact lenses fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include, but are not limited to, toric and multifocal.

**Anthem Extras Packages** additional programs

|                      | Standard Package | Premium Package<br>with SilverSneakers      | Premium Package<br>without SilverSneakers | Premium Plus Package<br>with SilverSneakers                                                                        | Premium Plus Package<br>without SilverSneakers                                                                     | Dental Policy<br>Only |
|----------------------|------------------|---------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|-----------------------|
| Travel assistance    | Not available    | Not available                               | Not available                             | If you have an emergency medical situation while traveling, travel assistance can help you as described on page 3. | If you have an emergency medical situation while traveling, travel assistance can help you as described on page 3. | Not available         |
| SilverSneakers       | Not available    | No copayment<br>Includes fitness membership | Not included                              | No copayment<br>Includes fitness membership                                                                        | Not included                                                                                                       | Not available         |
| Your monthly premium | \$25             | \$43                                        | \$38                                      | \$61                                                                                                               | \$56                                                                                                               | \$49                  |

**Other important information about Anthem Extras Packages and Dental Policy Only**

**Eligibility and enrollment**

- To be eligible for enrollment, you must be 65 years of age or older
- Please note these plans are not available for purchase by individuals enrolled or enrolling in Medicare Advantage plans

**Date coverage begins**

The effective date of your coverage will be printed on your member ID card

**How to enroll**

- Complete and sign the attached application
- Send the completed application, along with your first payment (if desired), to your agent or: Anthem Blue Cross, P.O. Box 5028, Denver, CO 80217-5028

**Extras Pay Now**

Through our electronic funds transfer (EFT) service, you can now see and pay your bills online. Do it one time. Do it every month. It’s up to you – and it’s easy to do! Go to **anthem.com/ca/anthemextraspackages** and choose Extras Pay Now under the Tools & Information section to sign up.

**Dental limitations and exclusions**

**► Standard Package**

This is a partial list of plan limitations and exclusions. Please see the Individual Dental Policy for a complete list.

**Limitations**

|                                                      |                                                                                                                                                                                   |
|------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Oral evaluations:</b>                             | Limited to 2 times per year                                                                                                                                                       |
| <b>Adult prophylaxis or periodontal maintenance:</b> | Limited to 2 times per year – in addition, a third cleaning or periodontal maintenance cleaning is applicable to diabetic members who enroll in our clinical integration program. |
| <b>Bitewing X-rays:</b>                              | Limited to 1 set (up to 4 films) once per year                                                                                                                                    |

**Exclusions**

- Charges for tobacco counseling, oral hygiene instruction, dietary planning or behavior management
- All hospital costs and any additional fees charged by the dentist for hospital treatment
- Professional visits for house/extended care facility, office visits after regularly scheduled hours and case presentations
- Charges for missed or cancelled appointments
- Services or supplies not specifically listed in the covered services section of the Individual Dental Policy

**► Premium Package, Premium Plus Package and Dental Policy Only**

This is a partial list of plan limitations and exclusions. Please see the Individual Dental Policy for a complete list.

**Limitations**

|                                                                                                             |                                                                                                                                                                                                                                                  |
|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Oral evaluations:</b>                                                                                    | Limited to 2 times per year                                                                                                                                                                                                                      |
| <b>Adult prophylaxis:</b>                                                                                   | Limited to 2 times per year singly or in combination with periodontal maintenance procedure. In addition, a third cleaning or periodontal maintenance cleaning is applicable to diabetic members who enroll in our clinical integration program. |
| <b>Full-mouth X-rays (complete series) or panoramic film:</b>                                               | Limited to 1 time every 5 years                                                                                                                                                                                                                  |
| <b>Bitewing X-rays:</b>                                                                                     | Limited to 1 series (up to 4 films) of bitewings once per calendar year                                                                                                                                                                          |
| <b>Amalgam and composite restorations:</b>                                                                  | Limited to once per tooth surface every 36 months. Benefits for composite resin restorations on posterior permanent teeth and primary teeth will be based on the Maximum Allowed Amount for the corresponding amalgam restoration.               |
| <b>Periodontal scaling:</b>                                                                                 | Limited to once per quadrant every 24 months                                                                                                                                                                                                     |
| <b>Periodontal surgery:</b>                                                                                 | Limited to 1 service per quadrant in any 3-year period                                                                                                                                                                                           |
| <b>Oral Surgery: Basic and surgical extractions. Root canal therapy and re-treatment (permanent teeth):</b> | Limited to 1 time per tooth/root per lifetime                                                                                                                                                                                                    |

Exclusions

- Replacement of existing fillings for any purpose other than restoring tooth structure
- General anesthesia, intravenous sedation

The following is not covered for the Anthem Extras Premium Package, but is covered in the Premium Plus Package and Premium Plus Dental plan:

- Services for prosthodontics; for example, crowns. Prosthodontics is the branch of dentistry dealing with the construction of artificial appliances for the mouth, especially for the purpose of replacing missing teeth with bridges and dentures

► Premium Plus Package Dental Policy Only

This is a partial list of plan limitations and exclusions. Please see the Individual Dental Policy for a complete list.

Limitations

|                                                        |                                                                                           |
|--------------------------------------------------------|-------------------------------------------------------------------------------------------|
| Permanent crowns and/or onlays:                        | Limited to 1 time per 7-year period per tooth                                             |
| Tissue conditioning:                                   | Limited to 2 times per arch in any 12-month period                                        |
| Relines:                                               | Limited to once per year for chairside reline and once in 3-5 years for laboratory reline |
| Removable prosthetic services (dentures and partials): | Limited to once per 7-year period                                                         |
| Denture adjustments:                                   | Limited to 1 time per year                                                                |
| Fixed prosthetic services (bridge):                    | Limited to 1 time per 7-year period                                                       |

Exclusions

- Replacement of an existing fixed or removable prosthesis for which benefits were paid if replacement occurs within seven years of the original placement
- Replacement of crowns, onlays and laboratory-fabricated restorations if replacement occurs within seven years of the original placement. Benefits will not be provided for a pontic or an abutment if a fixed or removable partial, crown or onlay was placed on the affected tooth/teeth in the last seven years
- Lost or stolen dentures or appliances. Replacement of existing full or partial dentures or appliances which have been lost or stolen
- Charges for any duplicate prosthetic device or appliance, or for a spare set of dentures or any other duplicate appliance
- Denture adjustments, repairs and reline are not covered for a period of six months from initial placement if the denture(s) was/were paid for under this Policy
- Temporary and interim prosthetics (temporary crowns, bridges, partials, dentures, etc.). Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits
- Teeth lost prior to coverage under this Policy are not eligible for prosthetic replacement unless the prosthetic replacement replaces one or more eligible natural teeth lost during the term of this coverage

Providing one source for your benefits

With Anthem, you get affordable coverage from one convenient, trusted source. Our products help address your overall health – from head to toe – and we do it with service and savings you will appreciate.

Enroll in one of our Anthem Extras Packages or our Dental Policy Only today. If you have any questions or need more information, call us toll-free at:

1-877-391-3897  
(8 a.m. – 5 p.m. local time)

TTY: 711



Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda.

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。！

Anthem complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

The purpose of this communication is the solicitation of insurance. Contact will be made by an insurance agent or insurance company.

This brochure is intended to be a brief summary of coverage and is not intended to be a legal contract. The entire provisions of benefits and exclusions are contained in the Policy; the Policy has exclusions, limitations and terms under which the Policy may be continued in force or discontinued. For costs and complete details of the coverage, call **1-877-391-3897** (8 a.m. – 5 p.m. local time) or write Anthem Blue Cross, P.O. Box 659444, San Antonio, TX 78265. In the event of a conflict between the Policy and this description, the terms of the Policy will prevail. Anthem Blue Cross is not connected with or endorsed by the U.S. Government or the federal Medicare program.

The International Emergency Dental Program is administered by DeCare Dental. No such relationship other than that of independent parties under an arrangement with each other solely for the purposes of providing dental care to Anthem Blue Cross members may be deemed to exist between DeCare Dental and participating dentists. DeCare Dental is an independent company offering dental administrative services to Anthem Blue Cross plans. DeCare Dental does not offer Anthem Blue Cross products or services. DeCare Dental is solely responsible for its products and services.

Travel assistance is provided by HTH Worldwide, and The SilverSneakers Fitness Program is provided by Healthways, Inc. Both HTH Worldwide and Healthways, Inc., are independent companies not affiliated with Anthem Blue Cross, and the services provided are not part of the insurance coverage provided by Anthem Blue Cross.

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

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