

# Dental Blue PPO University of Louisville

Effective Date: January 1, 2008

<b>Dental Blue Annual Deductible</b>	
Individual/Family	\$25 Individual / \$75 Family
Combined In and Out of Network	
<b>Dental Blue Annual Maximum</b>	\$1,000
<b>Network</b>	200

Where to Receive Services	Dental Blue PPO	
	PPO Dentists (In-network)	Non-PPO (Out-of-network)
<b>Diagnostic and preventive</b>	NCS/No deductible	25%/No deductible
<ul style="list-style-type: none"> <li>✎ Oral evaluations, x-rays</li> <li>✎ Cleanings</li> <li>✎ Sealants and fluoride</li> <li>✎ Space maintainers</li> </ul>		
<b>Minor restorative</b>	20% after deductible	40% after deductible
<ul style="list-style-type: none"> <li>✎ Emergency palliative pain treatment</li> <li>✎ Amalgam restorations (fillings)</li> <li>✎ Composite restoration (fillings)</li> <li>✎ Sedative fillings</li> <li>✎ Pin retention</li> </ul>		
<b>Oral surgery</b>	20% after deductible	40% after deductible
<ul style="list-style-type: none"> <li>✎ Simple extractions</li> <li>✎ Removal of impacted teeth</li> <li>✎ General anesthesia</li> </ul>		
<b>Endodontic services</b>	20% after deductible	40% after deductible
<ul style="list-style-type: none"> <li>✎ Root Canal Therapy</li> <li>✎ Therapeutic pulpotomy</li> <li>✎ Direct pulp capping</li> </ul>		
<b>Periodontal services</b>	20% after deductible	40% after deductible
<ul style="list-style-type: none"> <li>✎ Scaling and root planning</li> <li>✎ Gingivectomy</li> <li>✎ Osseous surgery</li> <li>✎ Soft tissue grafts</li> </ul>		
<b>Prosthodontic Services</b>	40% after deductible	60% after deductible
<ul style="list-style-type: none"> <li>✎ Crowns</li> <li>✎ Removable complete and partial dentures</li> <li>✎ Post and core</li> <li>✎ Bridge repair</li> <li>✎ Implants</li> <li>✎ Missing Teeth</li> </ul>	Not Covered Not Covered	Not Covered Not Covered
<b>Orthodontic Services</b>	50%/No deductible	50%/No deductible
<ul style="list-style-type: none"> <li>✎ Examinations</li> <li>✎ Records</li> <li>✎ Tooth guidance</li> <li>✎ Repositioning (straightening) of the teeth</li> </ul>		
<b>Orthodontic Maximum</b>	\$1,000	
<b>Orthodontic Age Limit</b>	Child to Age 25	

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

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

**No Cost Share (NCS)** means no deductible, copayment or coinsurance up to the maximum allowable amount. However, a member may be responsible for any balance due after the plan payment, including, but not limited to, benefits that reflect No Cost Share

## Limitations & Exclusions

**Limitations** — Here is a list of some of the limitations. Please see Certificate for full list:

**Oral Evaluations.** Limited to two per year.

**Prophylaxis or Periodontal Prophylaxis.** Prophylaxis or periodontal prophylaxis procedures are limited to two treatments per calendar year.

**Fluoride.** Fluoride treatment limited to two per year for 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 year.

**Sealants.** Sealants are limited to children under 16 years of age for permanent unrestored first and second molars. Treatment is limited to two applications 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.** Periodontal scaling is limited to once per quadrant every 24 months.

**Periodontal Surgery.** Periodontal surgery exceeding one time per quadrant in a 36-month period.

**Crown Lengthening.** Limited to once per tooth per lifetime.

**Root Canal Therapy.** 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/Onlays.** 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 —

Below is a list of some of the exclusions.

Please see Certificate for full list:

For analgesics (includes nitrous oxide) • For athletic mouth guards • For bleaching of discolored teeth • For crown buildups on the same tooth as an amalgam or composite restoration that was done within the same Benefit Year • For procedures to restore occlusion, vertical dimension or incisal edges due to bruxism, attrition or harmful habits • For diagnostic photographs, casts, or models • For procedures related to temporomandibular joint (TMJ) dysfunction, therapy or surgery, regardless of the reason(s) such services are necessary • For enamel microabrasion • For grafts to prepare for, or that are associated with implants • For implants and services or supplies, such as bridges, grafts, or dentures, that are provided in conjunction with implants • For local anesthetic when billed separately • For OSHA fees and/or infection control fees when billed separately • For precision attachments for partials and/or dentures • 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 (measured from the date on which the replaced Appliance was last prepared for the Member, whether under this Certificate of Coverage or under any prior dental coverage) • For restorations on the same tooth as a previously placed sealant if fewer than two years have elapsed since the time sealants were placed • For root canal therapy on deciduous teeth • For sealants on restored teeth (occlusal surface) • For second professional opinions • For temporary/interim prosthodontia or appliances (temporary crowns, bridges, partials, dentures, etc.) • For two similar services performed at the same time where one service is an integral part of a more extensive procedure • For biopsies except surgical biopsies • Prosthodontics and Orthodontics services may not apply based on the benefit plan selected • For services or supplies not specifically listed in the Certificate of Coverage.