



Anthem Pediatric Dental Benefits Frequently Asked Questions (FAQ)

Who can use this benefit? Is this benefit only available for new patients, or can new students and covered dependents who have had orthodontics prior to being covered through UC SHIP also utilize this benefit?

The pediatric dental benefit provides coverage for all eligible students and covered dependents through the age of 18, regardless of when they were first banded.

Is there a minimum age for utilizing this benefit?

There is no minimum age. Students and dependents are covered, with no minimum age, through the end of the month in which they turn 19. There was previously a limit specifying that orthodontics could not be obtained before the age of 8 and be covered; however, this minimum age requirement has been removed.

Is a referral required from the student health center in order for pediatric dental services to be covered?

A referral is not required for these services.

What is the benefit structure for pediatric dental services? What is the difference in reimbursement for Anthem network dental providers versus out-of-network providers?

Anthem has an established Maximum Allowable Amount for each dental service, just as with medical services. The same applies for Out-of-Network dental services, and a member who visits an Out-of-Network dentist may be balance-billed. Please see below for more specific reimbursement information, which is from the "Pediatric Dental Services" of the Benefit Booklet.



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PEDIATRIC DENTAL SERVICES

PEDIATRIC DENTAL DEDUCTIBLE.

Benefit Year Deductible. All pediatric dental services and supplies that are covered under this *plan* are subject to the *Benefit Year* Deductible listed below. Members are covered until the last day of the month in which the individual turns nineteen (19) years of age. The network and out-of-network deductibles are combined.

- Per Individual\$60
- Per Family.....\$120

PEDIATRIC DENTAL OUT-OF-POCKET AMOUNT. After you have made the following total out-of-pocket payments for covered charges incurred during a *Benefit Year*, you will no longer be required to pay a Co-Payment or Co-Insurance for the remainder of that *Benefit Year*, but you remain responsible for costs in excess of the *maximum allowed amount*.

- Per Individual\$1,000
- Per Family.....\$2,000

Payment Rates. After the Pediatric Dental Deductible has been satisfied, the *plan* will pay the percentage of the *maximum allowed amount* shown below, for the type of services received, up to the *maximum allowed amount*.

Dental Services	Network	Out-of Network
Diagnostic & Preventive Services, for example: <ul style="list-style-type: none"> • Periodic oral exam • Teeth cleaning • Bitewing X-rays 	\$0 Co-Payment	\$0 Co-Payment
Basic Services Fillings, for example: <ul style="list-style-type: none"> • Amalgam (silver-colored) • Anterior (front) composite (tooth-colored) • Posterior (back) composite covered at amalgam allowance 	50% Co-Insurance	50% Co-Insurance

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Endodontic Services , for example: <ul style="list-style-type: none">• Root canal	50% Co-Insurance	50% Co-Insurance
Periodontal Services , for example: <ul style="list-style-type: none">• Scaling and root planning	50% Co-Insurance	50% Co-Insurance
Oral Surgery Services	50% Co-Insurance	50% Co-Insurance
Major Services , for example: <ul style="list-style-type: none">• Crowns	50% Co-Insurance	50% Co-Insurance
Prosthodontic Services, for example: <ul style="list-style-type: none">• Dentures• Bridges	50% Co-Insurance	50% Co-Insurance
Dentally Necessary Orthodontic Services	50% Co-Insurance	50% Co-Insurance
Dentally Necessary Orthodontic Maximum	No Maximum	No Maximum
Cosmetic Orthodontic Services	Not covered	Not covered

Is there a dollar cap on the Pediatric Dental services?

There is no lifetime or annual benefit limit for Pediatric Dental services, including orthodontia. The only limit for pediatric dental benefits is the age requirement that the student or covered dependents must be under the age of 19.

It is indicated in the Benefit Booklet that Pediatric orthodontics must be deemed dentally/medically necessary. Is there a definition available for dentally/medically necessary orthodontics?

The following is available in the Benefit Booklet, under the “Dental Services – Pediatric” subheading of the “Medical Care that is Covered” provision. “Dentally Necessary” equates to “Medically Necessary.”



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Orthodontic Treatment

Orthodontic Treatment is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. The *plan* will only cover orthodontic care that is *medically necessary*. You or your dentist should submit your treatment plan to the *claims administrator* before you start any orthodontic treatment to make sure it is covered under this *plan*.

Medically Necessary Orthodontic Care

Medically necessary services will be subject to review. To be considered *medically necessary*, the service must meet criteria for *medically necessary* care as established by the *claims administrator*. The *plan* will cover orthodontic care when it is *medically necessary* to prevent disease and promote oral health, restore oral structures to health and function, and treat *emergency* and urgent conditions.

Your dental provider should submit a prior authorization form to Anthem for this service. This form is available by calling the telephone number listed on Your ID Card or online at www.anthem.com/ca. You may call customer service at the telephone number listed on Your ID Card to ask that a prior authorization form be faxed to your dentist.

The prior authorization process is outlined below:

- The Dental Professional Review area handles the review.
- If the Anthem defined criteria is met, the Dental Professional Review area will communicate to the dentist and Insured about the approval.
- If the Anthem defined criteria is NOT met, the Dental Professional Review area will communicate to the dentist and Insured about the denial.
- The letters of response contain steps for additional review, including information about filing a grievance.
- If prior authorization is denied you have the right to file a grievance.

The following conditions automatically qualify for *medically necessary* orthodontic care.

- Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed *specialist* must be submitted, on his or her professional letterhead, with the prior authorization request.
- Craniofacial anomaly. Written documentation from a credentialed *specialist* shall be submitted, on his or her professional letterhead, with the prior authorization request.
- Deep impinging overbite when the lower incisors are destroying the soft tissue of the palate and tissue laceration or clinical attachment loss is present.
- Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present.
- Severe traumatic deviation such as loss of a premaxilla segment by burns or accident, the result of osteomyelitis, or other gross pathology. Written documentation of the condition must be submitted with the prior authorization request.



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- Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5mm.

Orthodontic treatment may include the following:

- Limited Treatment – Treatments which are not full treatment cases and are usually done for minor tooth movement
- Interceptive Treatment – A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment
- Comprehensive (complete) Treatment – Full treatment includes all radiographs, diagnostic casts/models, appliances and visits
- Removable Appliance Therapy – An appliance that is removable and not cemented or bonded to the teeth
- Fixed Appliance Therapy – A component that is cemented or bonded to the teeth
- Complex Surgical Procedures – surgical exposure of impacted or unerupted tooth for orthodontic reasons; or surgical repositioning of teeth

Note: Treatment in progress (appliances placed prior to being covered under this *plan*) will be considered for benefits on a pro-rated basis

Orthodontic Exclusions

Coverage is NOT provided for:

- Repair or replacement of lost/broken/stolen appliances if more than twenty-four (24) months have passed since date of service for orthodontic retention.
- If the patient's orthodontic treatment is interrupted and orthodontic bands are prematurely removed, then the patient no longer qualifies for continued orthodontic treatment.
- If the patient's orthodontic bands have to be temporarily removed and then replaced due to a Medical Necessity, a claim for comprehensive orthodontic treatment of the adolescent dentition (D8080) for rebanding shall be submitted along with a letter from the treating Physician or radiologist, on their professional letterhead, stating the reason why the bands needed to be temporarily removed.

How does the Pediatric Dental Benefit coordinate with the UC SHIP Delta Dental plan?

For students under the age of 19, the Anthem Pediatric Dental plan is primary to the Delta Dental plan. Once a claim has been processed under the Anthem Pediatric Dental plan, the Insured is to submit the corresponding claim form and Anthem Explanation of Benefits to Delta Dental for secondary processing.



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How do I locate providers within Anthem's dental network?

Anthem contracted dental providers can be located on Anthem's website, www.anthem.com/ca, by following the navigation steps below:

Click on "Menu"

Click on "Find a Doctor" in the center column labelled "Care"

Under "Search as a Guest," click on "Search by Selecting a Plan or Network"

Under "What type of care are you searching for?" select "Dental"

Under "What state do you want to search in," select "California"

Under "Select a plan/network", select "Dental Prime"

Under "I'm searching for a," select "Dental Professional"

Leave the default selection for the reason for visit as "Routine dental visit"

Select the desired specialty, i.e. "Orthodontics" or "Pediatric Dentistry"

Input the desired location and mile radius for the search, and click "Search"