California
BENEFIT CHARTS

Anthem

Dental and vision

Benefit charts

2023 Individual and Family Plans

Plans off the Marketplace

Anthem Essential Choice PPO, Anthem Dental Net 3000D plans, and Blue View Vision plans

For plans effective January 1, 2023

1040253CAMENABC_OFF_2023 DAT 12/22

Anthem Essential Choice PPO plans

Cost shares show what the member pays	Essential Choice Bronze	Essential Choice Silver	Essential Choice Gold	Essential Choice Platinum	Essential Choice Incentive
	In-network / Out-of-network	In-network / Out-of-network	In-network / Out-of-network	In-network / Out-of-network	In-network / Out-of-network
Diagnostic and preventive	**No waiting period**	**No waiting period**	**No waiting period**	**No waiting period**	**No waiting period**
Cleaning, exams, x-rays	0% / 20% coinsurance	0% / 0% coinsurance	0% / 20% coinsurance	0% / 0% coinsurance	0% / 0% coinsurance
Basic services	**3-month waiting period**	**3-month waiting period**	**3-month waiting period**	**3-month waiting period**	**No waiting period**
Fillings	50% / 50% coinsurance	50% / 50% coinsurance	20% / 40% coinsurance	20% / 20% coinsurance	40% / 40% coinsurance *Rewards yearly preventive care by lowering the coinsurance by 10% the following year, up to 20% coinsurance on Basic and 50% on Major.*
Brush biopsy	Covered	Covered	Covered	Covered	Covered
Complex and major services (includes teeth whitening)	**Not covered**	**6-month waiting period**	**6-month waiting period**	**6-month waiting period**	**No waiting period**
Endodontic/periodontic/oral surgery (root canal, scaling, tooth removal)	Not covered	50% / 50% coinsurance	50% / 50% coinsurance	50% / 50% coinsurance	70% / 70% coinsurance *Rewards yearly preventive care by lowering the coinsurance by 10% the following year, up to 20% coinsurance on Basic and 50% on Major.*
Prosthetics (crowns, dentures, bridges)	Not covered	50% / 50% coinsurance	50% / 50% coinsurance	50% / 50% coinsurance	70% / 70% coinsurance *Rewards yearly preventive care by lowering the coinsurance by 10% the following year, up to 20% coinsurance on Basic and 50% on Major.*
Orthodontia (children covered up to age 19)	Not covered	Not covered	Not covered	$150 deductible, then 50% coinsurance *$1,000 lifetime maximum for orthodontia ($500 per year), after 12 month waiting period.*	$150 deductible, then 50% coinsurance *$1,000 lifetime maximum for orthodontia ($500 per year).*
Dental network	**Dental Prime**	**Dental Prime**	**Dental Prime**	**Dental Prime**	**Dental Prime**
Deductible (per person, unless otherwise noted)	$50 per person, $150 per family *Deductible is waived for diagnostic and preventive services received in our network.*	$50 per person, $150 per family *Deductible is waived for diagnostic and preventive services received in our network.*	$50 per person, $150 per family *Deductible is waived for diagnostic and preventive services received in our network.*	$50 per person, $150 per family *Deductible is waived for diagnostic and preventive services received in our network.*	$50 per person, $150 per family *Deductible is waived for diagnostic and preventive services received in our network.*
Annual maximum (per person)	**$1,000**	**$1,000**	**$1,500**	**$2,000**	**$2,500**
Annual out-of-pocket limit	**None**	**None**	**None**	**None**	**None**
International emergency dental program	Included	Included	Included	Included	Included

Dental HMO Option

With the Dental Net 3000D, you will have affordable dental coverage with no annual maximums, no deductibles and no benefit waiting periods. You will also know what out-of-pocket costs to expect because there are set copays on hundreds of procedures. Plan features include:

- Coverage for approximately 500 dental procedures
- No annual maximum benefit
- No deductible
- No waiting periods
- Easy-to-understand copayments
- Enhanced preventive care
- No claim forms
- A choice of general dentist and specialists

Services	Copays
Office visits	$10
Diagnostic and preventive services	
Exams	$0
X-rays	$0
Cleanings	$0
Flouride applications	$0
Sealants	$0
Restorative services	
Fillings (one surface resin composite, anterior)	$20
Fillings (one surface resin composite, posterior)	$65
Crowns (resin based composite, indirect)	$55
Endodontic services	
Root canals (anterior)	$90
Periodontal services	
Scaling and root planing (1 to 3 teeth)	$35
Prosthodontic services	
Dentures (complete upper or lower)	$215
Crown (porcelain fused to high noble metal)	$225
Oral surgery	
Extraction (Erupted tooth or exposed roots)	$5
Removal of impacted tooth (completely boney)	$90
Orthodontic services	
Comprehensive treatment children	$1,695
Comprehensive treatment, adults	$1,895

The services listed in the above chart are a sample of some of the most frequently asked-about procedures. For complete coverage details, please refer to your policy booklet.

Blue View Vision plans

The Blue View Vision Bundled plan can only be purchased with a medical and/or dental plan. All other Blue View Vision plans listed on these pages can be purchased with or without a medical and/or dental plan.

	Blue View Vision Bundled		Blue View Vision Enhanced		Blue View Vision Plus		Blue View Vision Value	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Eye exam (with dilation as needed)	$20 copay	$30 Reimbursement	$10 copay	$30 Reimbursement	$10 copay	$30 Reimbursement	$20 copay	$30 Reimbursement
Frequency	Once every 12 months	Once every 12 months	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Standard plastic (CR39) lenses								
Single vision	$20 copay	$25 Reimbursement	$10 copay	$25 Reimbursement	$20 copay	$25 Reimbursement	$20 copay	$25 Reimbursement
Bifocal	$20 copay	$40 Reimbursement	$10 copay	$40 Reimbursement	$20 copay	$40 Reimbursement	$20 copay	$40 Reimbursement
Trifocal	$20 copay	$55 Reimbursement	$10 copay	$55 Reimbursement	$20 copay	$55 Reimbursement	$20 copay	$55 Reimbursement
Frequency	Once every 24 months	Once every 24 months	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Lens add-ons								
Factory Scratch	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered
Tint	$15 copay	Not covered	$15 copay	Not covered	$15 copay	Not covered	$15 copay	Not covered
Standard anti-reflective coating	$45 copay	Not covered	$45 copay	Not covered	$45 copay	Not covered	$45 copay	Not covered
Standard progressive lens *The copay is in addition to bifocal copay.*	$65 copay	$40 Reimbursement	$65 copay	$40 Reimbursement	$65 copay	$40 Reimbursement	$65 copay	$40 Reimbursement
Polycarbonate								
Members under age 19	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered
Members age 19 and over	$40 copay	Not covered	$40 copay	Not covered	$40 copay	Not covered	$40 copay	Not covered
Transitions								
Members under age 19	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered
Members age 19 and over	$75 copay	Not covered	$75 copay	Not covered	$75 copay	Not covered	$75 copay	Not covered
Frequency	Once every 24 months	Once every 24 months	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Frames	$130 allowance	$45 Reimbursement	$150 allowance	$45 Reimbursement	$130 allowance	$45 Reimbursement	$130 allowance	$45 Reimbursement
Frequency	Once every 24 months	Once every 24 months	Once every calendar year	Once every calendar year	Once every other calendar year	Once every other calendar year	Once every other calendar year	Once every other calendar year
Contact lenses Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.								
Elective (conventional and disposable)	$80 allowance	$60 Reimbursement	$150 allowance	$60 Reimbursement	$130 allowance	$60 Reimbursement	$80 allowance	$60 Reimbursement
Nonelective	$0 copay	$210 Reimbursement	$0 copay	$210 Reimbursement	$0 copay	$210 Reimbursement	$0 copay	$210 Reimbursement
Frequency	Once every 24 months	Once every 24 months	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year

Blue View Vision plans

The Blue View Vision Bundled plan can only be purchased with a medical and/or dental plan. All other Blue View Vision plans listed on these pages can be purchased with or without a medical and/or dental plan.

	Blue View Progressive Preferred		Blue View Progressive Select		Blue View Vision Basic		Blue View Vision Premier	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Eye exam (with dilation as needed)	$10 copay	$30 Reimbursement	$10 copay	$30 Reimbursement	$20 copay	$30 Reimbursement	$10 copay	$30 Reimbursement
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Standard plastic (CR39) lenses								
Single vision	$10 copay	$25 Reimbursement	$20 copay	$25 Reimbursement	$20 copay	$25 Reimbursement	$20 copay	$25 Reimbursement
Bifocal	$10 copay	$40 Reimbursement	$20 copay	$40 Reimbursement	$20 copay	$40 Reimbursement	$20 copay	$40 Reimbursement
Trifocal	$10 copay	$55 Reimbursement	$20 copay	$55 Reimbursement	$20 copay	$55 Reimbursement	$20 copay	$55 Reimbursement
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Lens add-ons								
Factory Scratch	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered
Tint	$5 copay	Not covered	$5 copay	Not covered	$15 copay	Not covered	$5 copay	Not covered
Standard anti-reflective coating	$15 copay	Not covered	$15 copay	Not covered	$15 copay	Not covered	$15 copay	Not covered
Standard progressive lens *The copay is in addition to bifocal copay.*	$30 copay	$40 Reimbursement	$30 copay	$40 Reimbursement	$65 copay	$40 Reimbursement	$65 copay	$40 Reimbursement
Polycarbonate								
Members under age 19	$40 copay	Not covered	$40 copay	Not covered	$40 copay	Not covered	$40 copay	Not covered
Members age 19 and over	$10 copay	Not covered	$10 copay	Not covered	$10 copay	Not covered	$10 copay	Not covered
Transitions								
Members under age 19	$65 copay	Not covered	$65 copay	Not covered	$65 copay	Not covered	$65 copay	Not covered
Members age 19 and over	$20 copay	Not covered	$20 copay	Not covered	$20 copay	Not covered	$20 copay	Not covered
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Frames	$150 allowance	$45 Reimbursement	$130 allowance	$45 Reimbursement	$150 allowance	$45 Reimbursement	$180 allowance	$45 Reimbursement
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Contact lenses Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.								
Elective (conventional and disposable)	$150 allowance	$60 Reimbursement	$130 allowance	$60 Reimbursement	$150 allowance	$60 Reimbursement	$180 allowance	$60 Reimbursement
Nonelective	$0 copay	$210 Reimbursement	$0 copay	$210 Reimbursement	$0 copay	$210 Reimbursement	$0 copay	$210 Reimbursement
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year

Blue View Vision plans

The Blue View Vision Bundled plan can only be purchased with a medical and/or dental plan. All other Blue View Vision plans listed on these pages can be purchased with or without a medical and/or dental plan.

	Blue View Vision Ultra	
	In-network	**Out-of-network**
Eye exam (with dilation as needed)	$10 copay	$30 Reimbursement
Frequency	Once every calendar year	Once every calendar year
Standard plastic (CR39) lenses		
Single vision	$10 copay	$25 Reimbursement
Bifocal	$10 copay	$40 Reimbursement
Trifocal	$10 copay	$55 Reimbursement
Frequency	Once every calendar year	Once every calendar year
Lens add-ons		
Factory Scratch	$0 copay	Not covered
Tint	$5 copay	Not covered
Standard anti-reflective coating	$15 copay	Not covered
Standard progressive lens *The copay is in addition to bifocal copay.*	$65 copay	$40 Reimbursement
Polycarbonate		
Members under age 19	$40 copay	Not covered
Members age 19 and over	$10 copay	Not covered
Transitions		
Members under age 19	$65 copay	Not covered
Members age 19 and over	$20 copay	Not covered
Frequency	Once every calendar year	Once every calendar year
Frames	$200 allowance	$45 Reimbursement
Frequency	Once every calendar year	Once every calendar year
Contact lenses Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.		
Elective (conventional and disposable)	$200 allowance	$60 Reimbursement
Nonelective	$0 copay	$210 Reimbursement
Frequency	Once every calendar year	Once every calendar year

Limits and Exclusions

Exclusions - Blue View Vision

- Services not listed in the "Your Vision Benefits" section of the Agreement.
- Sunglasses. Sunglass lenses or accompanying frames.
- Any amounts in excess of the maximum benefits stated in the Agreement.
- Premium contact lenses fittings.
- Cosmetic lens options not specifically listed in the "What is Covered" section of the Agreement.
- Any non-prescription lenses, eyeglasses or contacts, or plano lenses or lenses that have no refractive power.
- Any diagnostic testing or medical or surgical treatment of the eyes, including any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia) and/or astigmatism. We also will not cover any contact lenses or eyeglasses required as a result of this surgery.
- Any lost or broken lenses or frames, unless you have reached a new benefit period.
- Services received before your effective date or after your coverage ends.
- Services for which you are not legally obligated to pay, for which you are not charged, or for which no charge is made in the absence of insurance coverage.
  Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation law or similar law, even if you do not claim those benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to any workers' compensation law or similar law, we will provide the benefits of this plan for such condition, subject to our right to a lien or other recovery applicable law.
  Any services actually given to you by a local, state, or federal government agency, or by a public school system or school district, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.
- Treatment or services rendered by non-licensed providers and treatment or services for which the provider of services is not required to be licensed.
- Services of relatives.
- Orthoptics or vision training and any associated supplemental testing.
- Missed or cancelled appointments.
- Services or supplies combined with any other offer, coupon or in-store advertisement.