



# **Dental and vision**

# Benefit charts

# **2023** Individual and Family Plans

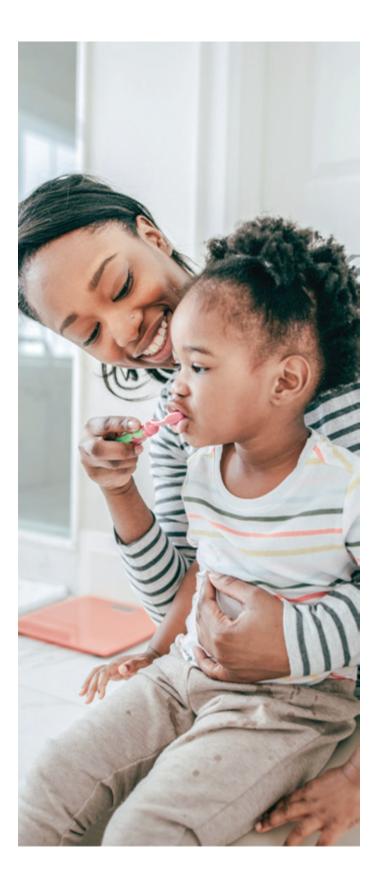
**Plans off the Marketplace** 

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

For plans effective January 1, 2023 ▷

# 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

Diagnostic and preventive services   \$0     Exams   \$0     Krays   \$0     Cleanings   \$0     Flouride applications   \$0     Sealants   \$0     Sealants   \$0     Restorative services   \$0     Fillings (one surface resin composite, anterior)   \$65     Crowns (resin based composite, posterior)   \$65     Crowns (resin based composite, indirect)   \$55     Endoctric services   \$10     Protoctric services   \$35     Protoctric services   \$35     Protoctric services   \$35     Protoctric services   \$35     Prosthodortic services   \$35     Prosthodortic services   \$225     Data services   \$235     Data services   \$235     Data services   \$2	Services	Copays
Exams\$0Xrays\$0Cleanings\$0Flouride applications\$0Sealants\$0Restorative services\$0Fillings (one surface resin composite, anterior)\$20Fillings (one surface resin composite, posterior)\$65Crowns (resin based composite, indirect)\$55Endodontic services\$90Pretiodontal services\$90Pretiodontal services\$215Dentures (complete upper or lower)\$255Crown (porcelain fused to high noble metal)\$225Oral surgery\$215Entraction (Frupted tooth or exposed roots)\$90Pertucation (Frupted tooth or exposed roots)\$90Orthodontic services\$90Entraction (Frupted tooth (completely boney)\$90Orthodontic services\$90Entraction (Frupted tooth (completely boney)\$90Orthodontic services\$90Entraction (Frupted tooth (completely boney)\$90Orthodontic services\$90Comprehensive treatment children\$1,695	Office visits	\$10
Araps\$0Cleanings\$0Cleanings\$0Bedratide applications\$0Sealants\$0Restorative services\$20Fillings (one surface resin composite, anterior)\$655Crowns (resin based composite, indirect)\$555Endodotic services\$90Pretodotal services\$90Pretodotal services\$90Pretodotal services\$35Pretodotal services\$35Dentures (complete upper or lower)\$35Corown (precelain fused to high noble metal)\$215Corown (precelain fused to high noble metal)\$225Oral surgery\$30Extraction (Erupted tooth or exposed roots)\$50Renoval of inpacted tooth (completely boney)\$30Orthodottic services\$30Comprehensive treatment children\$1,695	Diagnostic and preventive services	
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TotalSolutionSealants\$0Sealants\$0Restorative services\$20Fillings (one surface resin composite, anterior)\$65Crowns (resin based composite, nosterior)\$55Endodnic services\$90Protection (Sealants)\$90Periodnal services\$90Prosthodnic services\$90Prosthodnic services\$90Prosthodnic services\$90Prosthodnic services\$215Crown (porcelain fused to high noble metal)\$225Ord sugery\$225Extraction (Erupted tooth or exposed roots)\$90Prosthodnic services\$90Crown (porcelain fused tooth (completely boney)\$90Ordination (Services)\$90Comprehensive treatment children\$90Orthodnic services\$90Stateston (Erupted tooth or exposed roots)\$90Removal of inpacted tooth (completely boney)\$90Orthodnic services\$90Comprehensive treatment children\$1,695	X-rays	\$0
The services \$0   Restorative services \$20   Fillings (one surface resin composite, anterior) \$20   Fillings (one surface resin composite, posterior) \$65   Crowns (resin based composite, indirect) \$55   Endodontic services \$90   Root canals (anterior) \$90   Periodontal services \$90   Scaling and root planing (1 to 3 teeth) \$35   Posthodontic services \$215   Corown (porcelain fused to high noble metal) \$225   Dentures (complete upper or lower) \$1   Crown (porcelain fused to high noble metal) \$5   Restraction (Erupted tooth or exposed roots) \$5   Removal of inpacted tooth (completely boney) \$5   Comprehensive treatment children \$1,695	Cleanings	\$0
Restorative servicesFillings (one surface resin composite, anterior)\$20Fillings (one surface resin composite, posterior)\$65Crowns (resin based composite, indirect)\$55Endodntic services\$90Preiodontal services\$90Scaling and root planing (1 to 3 teeth)\$33Posthodontic services\$215Crown (porcelain fused to high noble metal)\$225Oral surgery\$225Extraction (Erupted tooth or exposed roots)\$90Removal of inpacted tooth (completely boney)\$90Chuber of Directed tooth (completely boney)\$90Chuber of Services\$90Dentures (complete upper or lower)\$90Comprehensive treatment children\$90Straction (Erupted tooth or exposed roots)\$90Comprehensive treatment children\$1,695	Flouride applications	\$0
Fillings (one surface resin composite, anterior)\$20Fillings (one surface resin composite, posterior)\$65Crowns (resin based composite, indirect)\$55Endodontic services\$90Protocanals (anterior)\$90Proidontal services\$35Prosthodntic services\$35Dentures (complete upper or lower)\$35Crown (porcelain fused to high noble metal)\$225Oral surgery\$225Extraction (Erupted tooth or exposed roots)\$5Removal of impacted tooth (completely boney)\$5Orthodontic services\$90Extraction (Erupted tooth (completely boney)\$90Comprehensive treatment children\$1,695	Sealants	\$0
Fillings (one surface resin composite, posterior)\$65Crowns (resin based composite, indirect)\$55Endodontic services\$90Periodontal services\$90Periodonti services\$35Scaling and root planing (1 to 3 teeth)\$35Posthodontic services\$215Dentures (complete upper or lower)\$225Oral surgery\$225Extraction (Erupted tooth or exposed roots)\$5Removal of impacted tooth (completely boney)\$90Orthodontic services\$90Extraction Erupted tooth (completely boney)\$1,695	Restorative services	
Crowns (resin based composite, indirect)\$55Endodontic services\$90Periodontal services\$90Scaling and root planing (1 to 3 teeth)\$35Posthodontic services\$215Dentures (complete upper or lower)\$225Crown (porcelain fused to high noble metal)\$225Oral surgery\$90Extraction (Erupted tooth or exposed roots)\$90Removal of impacted tooth (completely boney)\$90Orthodontic services\$90Comprehensive treatment children\$1,695	Fillings (one surface resin composite, anterior)	\$20
Endodontic servicesRoot canals (anterior)\$90Periodontal services\$35Scaling and root planing (1 to 3 teeth)\$35Prosthodontic services\$215Dentures (complete upper or lower)\$225Crown (porcelain fused to high noble metal)\$225Oral surgery\$5Extraction (Erupted tooth or exposed roots)\$90Removal of impacted tooth (completely boney)\$90Orthodontic services\$90Comprehensive treatment children\$1,695	Fillings (one surface resin composite, posterior)	\$65
Root canals (anterior)\$90Periodontal servicesScaling and root planing (1 to 3 teeth)\$35Prosthodontic servicesDentures (complete upper or lower)\$215Crown (porcelain fused to high noble metal)\$225Oral surgery\$215Extraction (Erupted tooth or exposed roots)\$5Removal of impacted tooth (completely boney)\$90Orthodontic services\$90Comprehensive treatment children\$1,695	Crowns (resin based composite, indirect)	\$55
Periodontal services \$35   Scaling and root planing (1 to 3 teeth) \$35   Prosthodontic services \$215   Dentures (complete upper or lower) \$215   Crown (porcelain fused to high noble metal) \$225   Oral surgery \$5   Extraction (Erupted tooth or exposed roots) \$5   Removal of impacted tooth (completely boney) \$90   Orthodontic services \$1,695	Endodontic services	
Scaling and root planing (1 to 3 teeth)\$35Prosthodontic servicesDentures (complete upper or lower)\$215Crown (porcelain fused to high noble metal)\$225Oral surgeryExtraction (Erupted tooth or exposed roots)\$5Removal of impacted tooth (completely boney)\$90Orthodontic servicesComprehensive treatment children\$1,695	Root canals (anterior)	\$90
Prosthodontic servicesDentures (complete upper or lower)\$215Crown (porcelain fused to high noble metal)\$225Oral surgery\$25Extraction (Erupted tooth or exposed roots)\$5Removal of impacted tooth (completely boney)\$90Orthodontic services\$1,695	Periodontal services	
Dentures (complete upper or lower)\$215Crown (porcelain fused to high noble metal)\$225Oral surgery*********************************	Scaling and root planing (1 to 3 teeth)	\$35
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 \$1,695	Prosthodontic services	
Oral surgeryExtraction (Erupted tooth or exposed roots)\$5Removal of impacted tooth (completely boney)\$90Orthodontic services\$1,695	Dentures (complete upper or lower)	\$215
Extraction (Erupted tooth or exposed roots) \$5 Removal of impacted tooth (completely boney) \$90 Orthodontic services Comprehensive treatment children \$1,695	Crown (porcelain fused to high noble metal)	\$225
Removal of impacted tooth (completely boney)\$90Orthodontic services\$1,695Comprehensive treatment children\$1,695	Oral surgery	
Orthodontic services   Comprehensive treatment children \$1,695	Extraction (Erupted tooth or exposed roots)	\$5
Comprehensive treatment children \$1,695	Removal of impacted tooth (completely boney)	\$90
	Orthodontic services	
Comprehensive treatment, adults \$1,895	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 сорау	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 сорау	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 сорау	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 calenda year			
<b>Contact lenses</b> Contact lens allowance will only be app be used for subsequent purchases in t	· · · · ·							
Elective (conventional and disposable)	\$80 allowance	\$60 Reimbursement	\$150 allowance	\$60 Reimbursement	\$130 allowance	\$60 Reimbursement	\$80 allowance	\$60 Reimbursement
Nonelective	\$0 сорау	\$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

#### Vision Value

#### Out-of-network

#### \$60 Reimbursement

# **Blue View Vision plans**

Frequency

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 Visi	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	
Eye exam (with dilation as needed)	\$10 copay	\$30 Reimbursement	\$10 copay	\$30 Reimbursement	\$20 copay	\$30 Reimbursement	\$10 copay	
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	(
Standard plastic (CR39) lenses								
Single vision	\$10 copay	\$25 Reimbursement	\$20 copay	\$25 Reimbursement	\$20 copay	\$25 Reimbursement	\$20 copay	
Bifocal	\$10 copay	\$40 Reimbursement	\$20 copay	\$40 Reimbursement	\$20 copay	\$40 Reimbursement	\$20 copay	
Trifocal	\$10 copay	\$55 Reimbursement	\$20 copay	\$55 Reimbursement	\$20 copay	\$55 Reimbursement	\$20 copay	
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	(
Lens add-ons								
Factory Scratch	\$0 copay	Not covered	\$0 copay	Not covered	\$0 copay	Not covered	\$0 copay	
Tint	\$5 copay	Not covered	\$5 copay	Not covered	\$15 copay	Not covered	\$5 copay	
Standard anti-reflective coating	\$15 copay	Not covered	\$15 copay	Not covered	\$15 copay	Not covered	\$15 copay	
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	
Polycarbonate								
Members under age 19	\$40 copay	Not covered	\$40 copay	Not covered	\$40 copay	Not covered	\$40 copay	
Members age 19 and over	\$10 copay	Not covered	\$10 copay	Not covered	\$10 copay	Not covered	\$10 copay	
Transitions								
Members under age 19	\$65 copay	Not covered	\$65 copay	Not covered	\$65 copay	Not covered	\$65 copay	
Members age 19 and over	\$20 copay	Not covered	\$20 copay	Not covered	\$20 copay	Not covered	\$20 copay	
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	(
Frames	\$150 allowance	\$45 Reimbursement	\$130 allowance	\$45 Reimbursement	\$150 allowance	\$45 Reimbursement	\$180 allowance	
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	(
<b>Contact lenses</b> Contact lens allowance will only be ap be used for subsequent purchases in		-		-				
Elective (conventional and disposable)	\$150 allowance	\$60 Reimbursement	\$130 allowance	\$60 Reimbursement	\$150 allowance	\$60 Reimbursement	\$180 allowance	
Nonelective	\$0 copay	\$210 Reimbursement	\$0 copay	\$210 Reimbursement	\$0 сорау	\$210 Reimbursement	\$0 copay	

#### ision Premier

#### Out-of-network

\$30 Reimbursement Once every calendar year

\$25 Reimbursement \$40 Reimbursement \$55 Reimbursement Once every calendar year

Not covered Not covered Not covered \$40 Reimbursement

> Not covered Not covered

Not covered Not covered Once every calendar year \$45 Reimbursement Once every calendar year

#### \$60 Reimbursement

\$0 copay\$210 Reimbursement\$0 copay\$210 Reimbursement\$0 copay\$210 Reimbursement0nce every calendar year0nce 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	
<b>Contact lenses</b> Contact lens allowance will only be app a benefit period. Any unused amount of the same benefit period, nor can any u period.	emaining cannot be used fo	or subsequent purchases in	
Elective (conventional and disposable)	\$200 allowance	\$60 Reimbursement	
Nonelective	\$0 copay	\$210 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.

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