Anthem BlueCross BlueShield

Good health starts with a healthy mouth.[1]
Good dental health and routine visits to your dentist can pay off in a bigger way than just having a healthy smile. Conditions in the mouth can, and often do, affect the rest of the body. Dental exams can help recognize as many as 120 medical conditions, making them extremely important to your overall health.

This benefit summary outlines the basics of your Anthem Dental Family Plan, providing you with a quick reference of deductibles, coinsurance amounts, limitations and exclusions when you receive covered services from a participating dental provider. Please refer to the plan certificate for a more complete explanation of the specific services covered by the plan.

Anthem Dental Family Enhanced Plan
Individuals and Small Groups

PEDIATRIC DENTAL BENEFITS AT A GLANCE:

The following benefits are available to pediatric members through age 18. After you have met your annual deductible, Anthem will pay for Dental services at the listed coinsurance amounts up to the Maximum Allowed Charge (MAC) as determined by Anthem for each covered service. However, there may be different levels of coinsurance, depending on whether you choose to receive services from a Participating (In-Network) or a Nonparticipating (Out-of-Network) dentist.

Coverage Year	**Calendar Year**
Insured Age Limit	**End of month in which insured turns age 19**
Annual Deductible (per insured child; applies to all services)	**$25**
Waiting Periods	**None**

DENTAL SERVICES (examples of what is/is not covered by the plan):	**IN-NETWORK** Anthem pays:	**OUT-OF-NETWORK** Anthem pays:
Annual Benefit Maximum	No maximum	No maximum
Annual Out-of-Pocket Maximum	$350 / $700 per family[2]	Not applicable
Diagnostic & Preventive Services, for example: • Periodic oral exam • Teeth cleaning • Bitewing X-rays	100%	80%
Basic Services, for example: • Amalgam (silver-colored) fillings • Anterior (front) composite (tooth-colored) fillings • Posterior (back) composite fillings covered at amalgam allowance	80%	60%
Endodontic Services, for example: • Root canal	80%	50%
Periodontal Services, for example: • Scaling and root planing	80%	50%
Oral Surgery Services	80%	50%
Major Services, for example: • Crowns	50%	50%
Prosthodontic Services, for example: • Dentures and bridges	50%	50%
Dentally Necessary and Cosmetic Orthodontic Services[3]	50%	50%
Dentally Necessary Orthodontic Maximum	No maximum	No maximum
Cosmetic Orthodontic Lifetime Maximum	$1,000	$1,000

[1]According to research, signs and symptoms of as many as 120 medical conditions can be first detected by an examination of the mouth, throat and neck – and earlier detection means earlier treatment. (Source: Oral Diagnosis, Oral Medicine and Treatment Planning, 1994, S. Bricker, R. Langlais, C. Miller.)
[2]Family out-of-pocket maximum applies if there are two or more children per family only; there is no out-of-pocket maximum for children receiving out-of-network services.
[3]Child orthodontic coverage begins at age eight. This means that the child must have been banded after age eight in order to receive coverage.

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ADULT DENTAL BENEFITS AT A GLANCE:

The following benefits are available to adult members over age 18. After you have met your Deductible, Anthem will pay for Dental services at the listed coinsurance amounts up to the Maximum Allowed Charge (MAC) for each covered service. Anthem determines the Maximum Allowed Charge payable for each dental procedure. However, there may be different levels of coinsurance, depending upon whether you choose to receive services from a Participating (In-Network) or a Nonparticipating (Out-of-Network) dentist.

Coverage Year	**Calendar Year**
Annual Deductible (per insured; applies to all services)	**$50**
Waiting Periods	• **None for Diagnostic & Preventive Services** • **Six months for Basic Services** • **Twelve months for all other services**

DENTAL SERVICES (examples of what is/is not covered by the plan):	**IN-NETWORK** Anthem pays:	**OUT-OF-NETWORK** Anthem pays:
Annual Benefit Maximum	$1,000	$1,000
Annual Out-of-Pocket Maximum	Not applicable	Not applicable
Diagnostic & Preventive Services, for example: • Periodic oral exam • Teeth cleaning • Bitewing X-rays	100%	50%
Basic Services **Fillings, for example:** • Amalgam (silver-colored) • Anterior (front) composite (tooth-colored) • Posterior (back) composite covered at amalgam allowance	80%	40%
Endodontic Services, for example: • Root canal	50%	25%
Periodontal Services, for example: • Scaling and root planing	50%	25%
Oral Surgery Services	50%	25%
Major Services, for example: • Crowns	50%	25%
Prosthodontic Services, for example: • Dentures and bridges	50%	25%
Orthodontic Services	Not covered	Not covered

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of your certificate of coverage. **In the event of a discrepancy between the information in this summary and the certificate of coverage, the certificate will prevail.**

The in-network dental providers mentioned in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of Anthem Blue Cross Blue Shield.

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Choice of dentists
While your dental plan lets you choose any dentist, you may end up paying more for a service if you visit an out-of-network dentist. Why? Because 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 is called "balance billing."

How Anthem dental decides on maximum allowed amounts
For Anthem develops an out-of-network dental fee schedule/rate to determine the maximum allowed cost (MAC) for services provided by an out-of-network dentist. This schedule may be changed or updated based on such things as reimbursement amounts accepted by dentists contracted with our dental plans, or other industry cost and usage data.

Here's an example of higher costs for out-of-network dental services
This is an example only. Your experience may be different, depending on your insurance plan, the services you receive and the dentist who provides the services.

Ted, a 28-year-old, 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 charge 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 $600 coinsurance, the total he'll pay the out-of-network dentist is $1,000. Here's the math:

- Dentist's charge: $1,200
- Anthem's maximum allowed amount: $800
- Anthem pays 25%: $200
- Ted pays 75% (coinsurance): **$600**
- Balance Ted owes the provider: $1,200 - $800 = **$400**
- Ted's total cost: **$600** coinsurance + **$400** provider balance = **$1,000**

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 and Anthem would have paid a higher coinsurance (50%).

Emergency dental treatment for the international traveler
As an Anthem dental member, you and your eligible, covered dependents automatically have access to the International Emergency Dental Program.** With this program, you may receive emergency dental care from our listing of credentialed dentists while traveling or working nearly anywhere in the world.
** The International Emergency Dental Program is managed by DeCare Dental, an independent company offering dental-management services to Anthem.

Finding a dentist is easy.
To select a dentist by name or location: • Go to anthem.com/mydentalvision • Call Anthem dental Customer Service

TO CONTACT US:

Call	Write
Call the toll-free number on the back of your member ID card to speak with a U.S.-based customer service representative during normal business hours. Calling after hours? We may still be able to assist you with our interactive voice-response system.	Refer to the back of your member ID card for the address.

Anthem does not discriminate based on race, color, ethnicity, national origin, religion, age, gender, gender identity, mental or physical disabilities, sexual orientation, genetic information, including pregnancy and expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health condition or health status in the administration of the plan (including enrollment, marketing practices, benefit designs, and benefit determinations).

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Limitations & Exclusions (Pediatric Benefits)

Limitations – Below is a partial listing of dental plan limitations. Please see your certificate of coverage for a full list.

Diagnostic and Preventive Services
Oral evaluations (exams) Limited to one time per six-month period
Teeth cleaning (prophylaxis) Covered one time per six-month period
Bitewing X-rays Limited to one series of films per year
Complete series X-rays (panoramic or full-mouth) Covered one time per 60-month period
Topical application of fluoride Covered once per six-month period
Topical application of fluoride varnish Covered once per six-month period
Sealants Covered once per tooth per lifetime
Space maintainers (fixed unilateral, fixed bilateral, removable unilateral) Covered one time per quadrant every 12 months

Basic Services
Fillings Covered once per tooth surface per 12-month period; composite (white) resin restorations to repair decayed or fractured permanent or primary anterior (front) teeth; amalgam (silver) restorations to repair decayed or fractured permanent or primary posterior (back) teeth; composite restorations for posterior teeth covered at amalgam (silver) allowance
Extractions Basic removal of teeth
Root canal therapy Covered once per tooth per lifetime
Periodontal services (such as scaling and root planing) Covered one time per two years per quadrant
Surgical extractions Removal of third molars covered only with symptoms of oral pathology
Intravenous/nonintravenous conscious sedation and general anesthesia Covered only when given with covered oral surgery services in dental office by a dentist (or employee of the dentist) who is certified to provide anesthesia services; up to a maximum of 150 minutes (10 units)

Major/Other Services
Prefabricated, stainless steel or temporary crowns Covered as needed per pathology; temporary crown not covered if used during crown fabrication
Permanent Crowns (high noble metal, porcelain only, or metal/porcelain) Covered one time per 60-month period for permanent teeth only
Prosthodontic services (dentures, partials, bridges) Covered one time per 60-month period

Orthodontic Services
Dentally necessary orthodontic services Limited one course of treatment per member per lifetime for dentally necessary orthodontic services only; to be considered dentally necessary orthodontic care, at least one of the following criteria must be present:
a. There is spacing between adjacent teeth that interferes with the biting function;
b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when child bites;
c. Positioning of the jaws or teeth impair chewing or biting function;
d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.
Cosmetic orthodontic services Covered for insureds through age 18

Exclusions – Below is a partial listing of noncovered services. Please see your certificate of coverage for a full list.

Services provided before or after the term of this coverage Services received before your effective date or after coverage ends, unless otherwise specified in the dental plan certificate
Cosmetic dentistry Services provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist

Limitations & Exclusions (Adult Benefits)

Limitations – Below is a partial listing of dental plan limitations. Please see your Certificate of Coverage for a full list.

Diagnostic and Preventive Services
Oral evaluations (exams) Limited to two per calendar year
Teeth cleaning (prophylaxis) Limited to two per calendar year
Bitewing X-rays Limited to one series of films per 24-month period
Periapical X-rays Limited to four single X-rays per 12-month period
Occlusal X-rays Covered at two series per 24-month period
Complete series X-rays (panoramic or full-mouth) Limited to one series in any 60-month period

Basic Services
Fillings Replacement of a filling is covered only if it is defective, as evidenced by decay or fracture. Limited to one service per tooth surface per 24-month period
Basic Extractions Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth; extraction of erupted tooth or exposed root
Brush biopsy Limited to one time per 36-month period per member age 20 to 39; covered one time per 12-month period per member age 40 and above

Major/Other Services
Crowns Limited to once per tooth in a seven-year period
Fixed prosthodontics – bridges Covered once per seven-year period
Removable prosthodontics – dentures and partials Covered once per seven-year period
Root canal therapy Limited to once per lifetime per tooth for permanent teeth only.
Periodontal scaling and root planing Limited to once per quadrant in 36 months when the tooth pocket has a depth of four millimeters or greater
Periodontal surgery Limited to one complex service per single tooth or quadrant in any 36 months, and only if the pocket depth of the tooth is five millimeters or greater

Exclusions – Below is a partial listing of noncovered services. Please see your Certificate of Coverage for a full list.

Services provided before or after the term of this coverage Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate
Orthodontic services Orthodontic braces, appliances and all related services
Cosmetic dentistry Services provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist
Drugs and medications Intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care; analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.
Extractions Surgical removal of asymptomatic, nonpathologic third molars