

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 Blue Cross and Blue Shield (Anthem) Dental Family Enhanced 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 covered child; applies to all services)	\$25
Waiting Periods	Twelve months for cosmetic orthodontic 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	No maximum	No maximum
Annual Out-of-Pocket Maximum	\$350 / \$700 per family ²	Not applicable
Diagnostic & Preventive Services, for example: <ul style="list-style-type: none"> • Periodic oral exam • Teeth cleaning • Bitewing X-rays 	100%	80%
Basic Services, for example: <ul style="list-style-type: none"> • Amalgam (silver-colored) fillings • Anterior (front) composite (tooth-colored) fillings 	80%	60%
Endodontic Services, for example: <ul style="list-style-type: none"> • Root canal 	80%	50%
Periodontal Services, for example: <ul style="list-style-type: none"> • Scaling and root planing 	80%	50%
Oral Surgery Services	80%	50%
Major Services, for example: <ul style="list-style-type: none"> • Crowns 	50%	50%
Prosthetic Services, for example: <ul style="list-style-type: none"> • 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

¹According 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.)

²Family 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.

³Child cosmetic orthodontic coverage begins at age eight. This means that the child must have been banded after age eight in order to receive coverage.

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 covered person; applies to all services)	\$50
Waiting Periods	<ul style="list-style-type: none"> • 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	
Annual Out-of-Pocket Maximum	Not applicable	Not applicable
Diagnostic & Preventive Services, for example: <ul style="list-style-type: none"> • Periodic oral exam • Teeth cleaning • Bitewing X-rays 	100%	50%
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 	80%	40%
Endodontic Services, for example: <ul style="list-style-type: none"> • Root canal 	50%	25%
Periodontal Services, for example: <ul style="list-style-type: none"> • Scaling and root planing 	50%	25%
Oral Surgery Services	50%	25%
Major Services, for example: <ul style="list-style-type: none"> • Crowns 	50%	25%
Prosthetic Services, for example: <ul style="list-style-type: none"> • 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.

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

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.

*Managed by an independent company offering dental management services to Anthem Blue Cross and Blue Shield. To learn more about the program, please visit the International Emergency Dental website at www.decare.com/internationalDentalProgram.do.

Finding a dentist is easy.

To select a dentist by name or location:

- Go to anthem.com or the website listed on your member ID card.
- Call Anthem dental Customer Service.

TO CONTACT US:

Call	Write	Email
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.	Look to the back of your member ID card for the address.	Go to anthem.com or the website listed on the back of your ID card.

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).

Limitations & Exclusions (Pediatric Benefits)

<p>Limitations – Below is a partial listing of dental plan limitations. Please see your certificate of coverage for a full list.</p> <p><u>Diagnostic and Preventive Services</u> Oral evaluations (exams) Limited to two per 12-month period Teeth cleaning (prophylaxis) Limited to two per 12-month period Bitewing X-rays Limited to two series of films per 12-month period Complete series X-rays (panoramic or full-mouth) Limited to one series in any 60-month period Fluoride treatments Covered two times per 12-month period Sealants Limited to permanent molars; covered one time per 36-month period</p> <p><u>Basic Services</u> Fillings Amalgam (silver) to restore posterior (back) teeth; composite (white) to restore anterior (front) teeth Prefabricated or stainless steel crowns Covered once per tooth in a 60-month period Extractions Basic removal of teeth</p> <p><u>Major/Other Services</u> Prosthodontic services (dentures, partials, bridges) Covered one time per 60-month period Complex surgical extractions Removal of impacted teeth covered only with evidence of pathology Periodontal services (such as scaling and root planing) Covered one time per 24-month period Root canal therapy Covered on permanent teeth only</p>	<p><u>Orthodontic Services</u> Dentally necessary orthodontic services Limited to 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 pediatric insureds through age 18</p> <p>Exclusions – Below is a partial listing of noncovered services. Please see your certificate of coverage for a full list.</p> <p>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 Drugs and medications Analgesia, analgesic agents, anxiolysis nitrous oxide, medicines or drugs for nonsurgical or surgical dental care</p>
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Limitations & Exclusions (Adult Benefits)

<p>Limitations – Below is a partial listing of dental plan limitations. Please see your Certificate of Coverage for a full list.</p> <p><u>Diagnostic and Preventive Services</u> 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</p> <p><u>Basic Services</u> 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</p> <p><u>Major/Other Services</u> 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; coverage is for permanent teeth only.</p>	<p>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</p> <p>Exclusions – Below is a partial listing of noncovered services. Please see your Certificate of Coverage for a full list.</p> <p>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</p>
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