

**Good health starts with a healthy mouth.<sup>1</sup>**

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 Preventive 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 Preventive Plan Individuals and Families

**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.

<b>Coverage Year</b>	<b>Calendar Year</b>
<b>Insured Age Limit</b>	<b>End of month in which insured turns age 19</b>
<b>Annual Deductible</b> (per covered child; applies to all services)	<b>\$50</b>
<b>Waiting Periods</b>	<b>None</b>

<b>DENTAL SERVICES</b> (examples of what is/is not covered by the plan):	<b>IN-NETWORK</b> Anthem pays:	<b>OUT-OF-NETWORK</b> Anthem pays:
<b>Annual Benefit Maximum</b>	No maximum	No maximum
<b>Annual Out-of-Pocket Maximum</b>	\$350 / \$700 per family <sup>2</sup>	Not applicable
<b>Diagnostic &amp; Preventive Services, for example:</b> <ul style="list-style-type: none"> <li>• Periodic oral exam</li> <li>• Teeth cleaning</li> <li>• Bitewing X-rays</li> </ul>	100%	70%
<b>Basic Services, for example:</b> <ul style="list-style-type: none"> <li>• Composite (tooth-colored) fillings on anterior (front) teeth</li> <li>• Amalgam (silver-colored) fillings on posterior (back) teeth</li> </ul>	60%	50%
<b>Endodontic Services, for example:</b> <ul style="list-style-type: none"> <li>• Root canal</li> </ul>	50%	50%
<b>Periodontal Services, for example:</b> <ul style="list-style-type: none"> <li>• Scaling and root planing</li> </ul>	50%	50%
<b>Oral Surgery Services</b>	50%	50%
<b>Major Services, for example:</b> <ul style="list-style-type: none"> <li>• Crowns</li> </ul>	50%	50%
<b>Prosthetic Services, for example:</b> <ul style="list-style-type: none"> <li>• Dentures and bridges</li> </ul>	50%	50%
<b>Dentally Necessary Orthodontic Services<sup>3</sup></b>	50%	50%
<b>Dentally Necessary Orthodontic Lifetime Maximum</b>	No maximum	No maximum

<sup>1</sup>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.)

<sup>2</sup>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.

**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.

<b>Coverage Year</b>	<b>Calendar Year</b>
<b>Annual Deductible</b> (per covered person; applies to all services)	<b>\$50</b>
<b>Waiting Periods</b>	<b>None</b>

<b>DENTAL SERVICES</b> (examples of what is/is not covered by the plan):	<b>IN-NETWORK</b> Anthem pays:	<b>OUT-OF-NETWORK</b> Anthem pays:
<b>Annual Benefit Maximum</b>	\$750	
<b>Annual Out-of-Pocket Maximum</b> (per insured)	Not applicable	Not applicable
<b>Diagnostic &amp; Preventive Services, for example:</b> <ul style="list-style-type: none"> <li>• Periodic oral exam</li> <li>• Teeth cleaning</li> <li>• Bitewing X-rays</li> </ul>	100%	70%
<b>Basic Services</b> <b>Fillings, for example:</b> <ul style="list-style-type: none"> <li>• Amalgam (silver-colored)</li> <li>• Anterior (front) composite (tooth-colored)</li> <li>• Posterior (back) composite covered at amalgam allowance</li> </ul>	Not covered	Not covered
<b>Endodontic Services, for example:</b> <ul style="list-style-type: none"> <li>• Root canal</li> </ul>	Not covered	Not covered
<b>Periodontal Services, for example:</b> <ul style="list-style-type: none"> <li>• Scaling and root planing</li> </ul>	Not covered	Not covered
<b>Oral Surgery Services</b>	Not covered	Not covered
<b>Major Services, for example:</b> <ul style="list-style-type: none"> <li>• Crowns</li> </ul>	Not covered	Not covered
<b>Prosthetic Services, for example:</b> <ul style="list-style-type: none"> <li>• Dentures and bridges</li> </ul>	Not covered	Not covered
<b>Orthodontic Services</b>	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 \$680 coinsurance, the total he'll pay the out-of-network dentist is \$1,080. Here's the math:

- Dentist's charge: \$1,200
- Anthem's maximum allowed amount: \$800
- Anthem pays 15%: \$120
- Ted pays 85% (coinsurance): **\$680**
- Balance Ted owes the provider: \$1,200 - \$800 = **\$400**
- Ted's total cost: **\$680** coinsurance + **\$400** provider balance = **\$1,080**

In the example, if Ted had gone to an in-network dentist, his cost would be only **\$560** for the coinsurance because he would not have been "balance billed" the \$400 difference and Anthem would have paid a higher coinsurance (30%).

### 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](http://www.decare.com/internationalDentalProgram.do).

### Finding a dentist is easy.

To select a dentist by name or location:

- Go to [anthem.com](http://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 <a href="http://anthem.com">anthem.com</a> 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)

**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 12-month period  
**Teeth cleaning** (prophylaxis) Limited to two 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

#### Basic Services

**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

#### Major/Other Services

**Prosthetic 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

#### 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:

- There is spacing between adjacent teeth that interferes with the biting function;
- There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when child bites;
- Positioning of the jaws or teeth impair chewing or biting function;
- On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
- Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

**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

**Cosmetic orthodontic services** Orthodontic braces, appliances and all related services that are not considered dentally necessary

**Drugs and medications** Analgesia, analgesic agents, anxiolysis nitrous oxide, medicines or drugs for nonsurgical or surgical dental care

### 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

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

#### Basic Services

Fillings  
 Basic Extractions  
 Brush biopsy

#### Major Services

Crowns, dentures, partials, bridges, tooth implants  
 Root canal therapy  
 Periodontal surgery, scaling and root planing  
 Oral surgery, includes surgical extractions

**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.

# Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

## Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

## Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

## Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

## Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

## Tagalog

May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

## Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

## Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجاناً. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة. (TTY/TDD: 711)

## Armenian

Ձեր իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

## Farsi

شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناساییتان درج شده است، تماس بگیرید. (TTY/TDD: 711)

## French

Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

#### Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

#### Haitian

Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

#### Italian

Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

#### Polish

Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

#### Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

#### Navajo

Bee ná ahoot'í t'áá ni nizaad k'ehjí níká a'doowoł t'áá jík'e. Naaltsoos bee atah nílínígíí bee néé'ho'dólingo nanitínígíí bécsh bee hane'í bikáá' ááj' hodiílnih. (TTY/TDD: 711)

#### **It's important we treat you fairly**

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.