

**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 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 Plan  
Individuals and Small Groups**

**PEDIATRIC DENTAL BENEFITS AT A GLANCE:**

The following benefits are available to pediatric members through age 20. 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 21</b>
<b>Annual Deductible</b> (per insured; 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> (per insured child; up to two children per family)	\$350 / \$700 per family <sup>2</sup>	Not applicable
<b>Diagnostic &amp; Preventive Services, for example:</b> • Periodic oral exam • Teeth cleaning • Bitewing X-rays	100%	70%
<b>Basic Services, for example:</b> • Composite (tooth-colored) fillings on anterior (front) teeth • Amalgam (silver-colored) fillings on posterior (back) teeth • Posterior (back) composite fillings covered at amalgam allowance	60%	50%
<b>Endodontic Services, for example:</b> • Root canal	50%	50%
<b>Periodontal Services, for example:</b> • Scaling and root planing	50%	50%
<b>Oral Surgery Services</b>	50%	50%
<b>Major Services, for example:</b> • Crowns	50%	50%
<b>Prosthodontic Services, for example:</b> • Dentures and bridges	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 adults or for children receiving out-of-network services.

<sup>3</sup>Child 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 age 21 and older. 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 insured; applies to all services)	<b>\$50</b>
<b>Waiting Periods</b>	<ul style="list-style-type: none"> <li>• <b>None for Diagnostic &amp; Preventive Services</b></li> <li>• <b>Six months for Basic Services</b></li> <li>• <b>Twelve months for all other services</b></li> </ul>

<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	\$750
<b>Annual Out-of-Pocket Maximum</b>	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%	50%
<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>	50%	25%
<b>Endodontic Services, for example:</b> <ul style="list-style-type: none"> <li>• Root canal</li> </ul>	30%	15%
<b>Periodontal Services, for example:</b> <ul style="list-style-type: none"> <li>• Scaling and root planing</li> </ul>	30%	15%
<b>Oral Surgery Services</b>	30%	15%
<b>Major Services, for example:</b> <ul style="list-style-type: none"> <li>• Crowns</li> </ul>	30%	15%
<b>Prosthodontic Services, for example:</b> <ul style="list-style-type: none"> <li>• Dentures and bridges</li> </ul>	30%	15%
<b>Orthodontic Services</b>	Not covered	Not covered

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

For services from an out-of-network dentist, the maximum allowed amount is determined in one of the following ways:

- Out-of-network dental fee schedule/rate developed by Anthem, which may be updated based on such things as reimbursement amounts accepted by dentists contracted with our dental plans, or other industry cost and usage data
- Information provided by a third-party vendor that shows comparable costs for dental services
- In-network dentist fee schedule

### 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.

\*\* 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](http://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.

**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 per calendar year
- Bitewing X-rays** Limited to four films per 12-month period
- Complete series X-rays** (panoramic or full-mouth) Limited to one series per 12-month period per member per provider.
- Sealants** Covered 1 time every 4 years for permanent first and second molars
- Space maintainers** Covered two times per 12-month period

**Basic Services**

- Fillings** Covered once per tooth surface per 24-month period
- Extractions** Basic removal of teeth

**Major/Other Services**

- Permanent Crowns** Covered if the tooth has extensive loss of natural tooth structure
- Root canal therapy** Coverage is for permanent teeth only.
- Surgical extractions** Removal of impacted teeth is covered only when evidence of pathology exists.

**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.

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

**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; coverage is 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 for either dentally necessary or cosmetic purposes
- 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