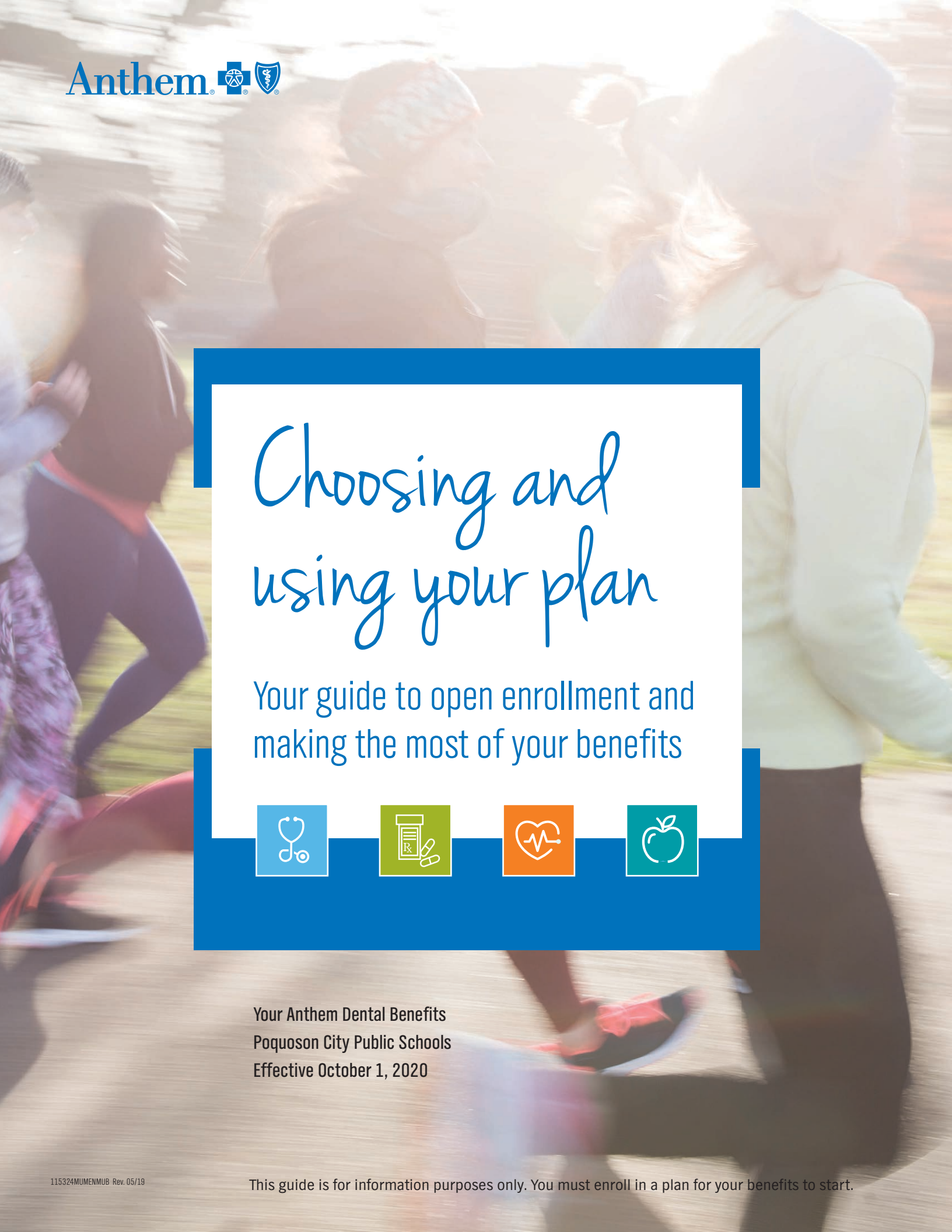


Anthem

Choosing and using your plan

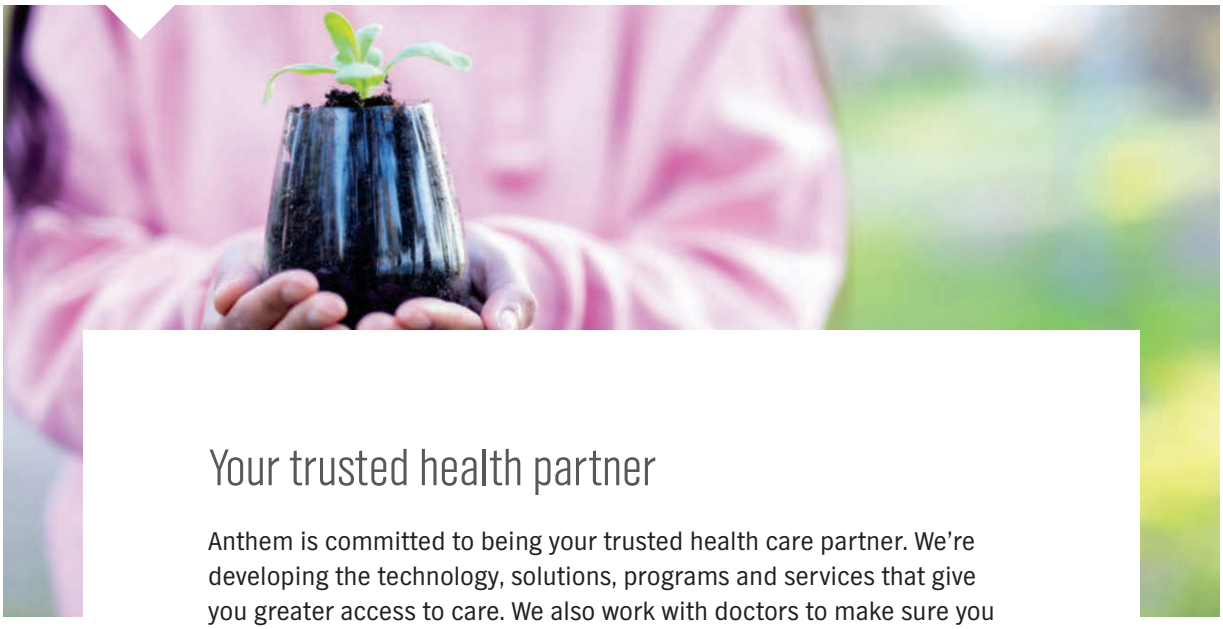
Your guide to open enrollment and making the most of your benefits

Your Anthem Dental Benefits
Poquoson City Public Schools
Effective October 1, 2020

115324MUMENMUB Rev. 05/19

This guide is for information purposes only. You must enroll in a plan for your benefits to start.

It’s time to choose your plan



Your trusted health partner

Anthem is committed to being your trusted health care partner. We’re developing the technology, solutions, programs and services that give you greater access to care. We also work with doctors to make sure you get affordable, quality health care.

Save this guide

You’ll find tips on how to make the most of your benefits and save on health care costs throughout the year.

Dental benefits

Dental PPO

Dental benefits not only protect your teeth, but can support overall health, too. Some conditions like heart disease, for example, can have warning signs in the mouth and gums. Our dental plan gives you all the benefits you need for a healthy mouth and more.

Visit **anthem.com/mydentalppo** to watch a video and learn more about a dental PPO plan.

Your dental plan benefits cover:

- Most preventive and diagnostic services at 100%. That includes things like cleanings and X-rays.
- More dental services, including an extra periodontal cleaning if you're enrolled in certain care management programs.
- Discounts through SpecialOffers@Anthem℠.

Use the **Sydney Health** app or visit **anthem.com** to:

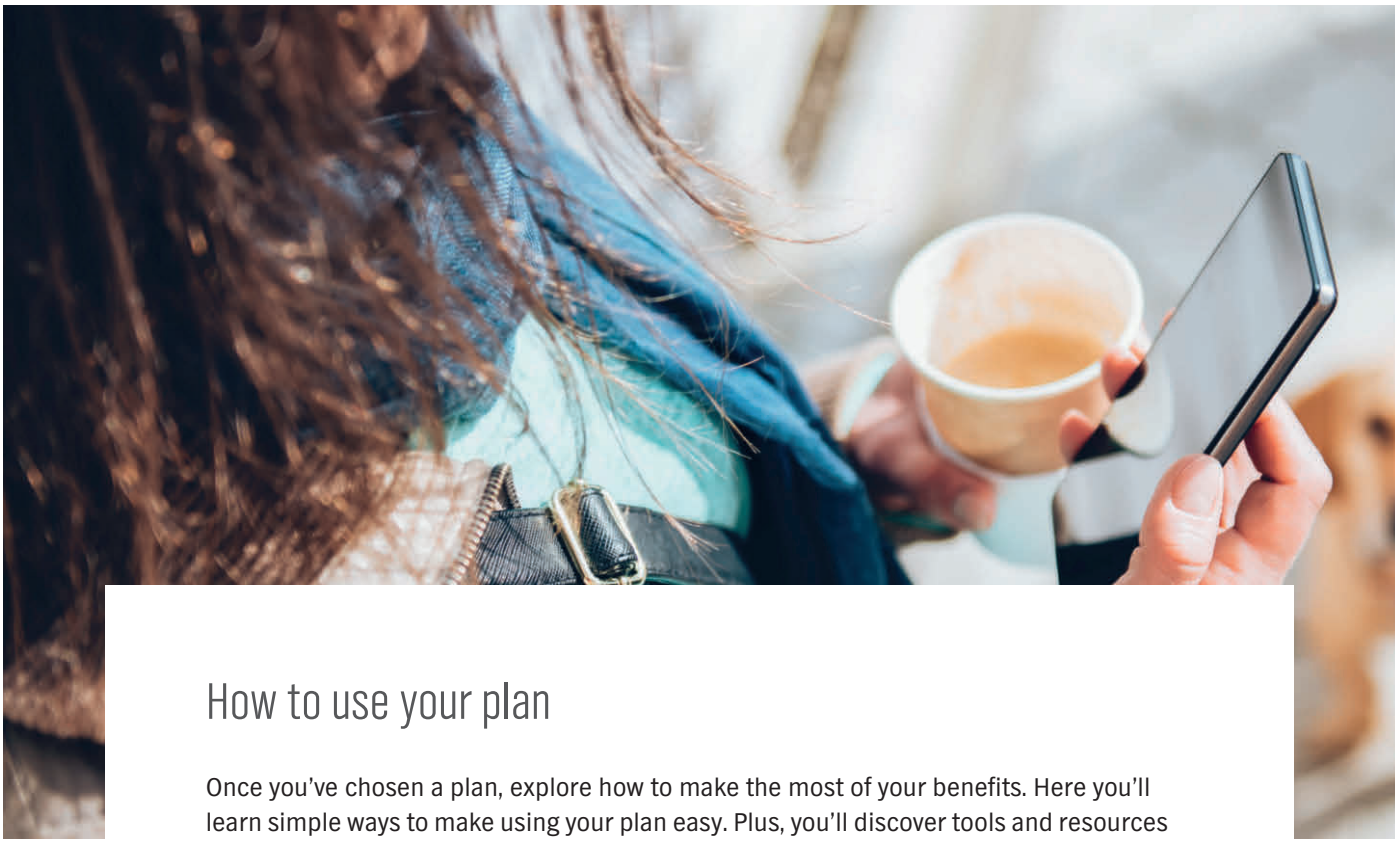
- Find a dentist in your plan and pay less.
- Order extra ID cards or use your mobile ID card through the **Sydney Health** app.
- Find out the status of a claim.
- Get a health score for your gums and teeth using our Dental Health Assessment tool.
- Email a dental hygienist your dental questions through our Ask a Hygienist tool.

Dental tools that won't hurt a bit

Your plan comes with handy tools to help you get the best care and save money:

- Dental Care Cost Estimator: Lets you estimate common dental procedures and treatments.
- The right dentist can make all the difference – and choosing one in your plan can save you money, too. Use our Find a Doctor tool on anthem.com.

Using your plan



How to use your plan

Once you've chosen a plan, explore how to make the most of your benefits. Here you'll learn simple ways to make using your plan easy. Plus, you'll discover tools and resources that can help you reach your health and wellness goals. With Anthem, supporting your healthiest self is all part of the plan!

How to use your plan

Use your ID card right from your phone

Introducing the **Sydney Health** mobile app. With **Sydney Health** you can find everything you need to know about your benefits – all in one place. You'll have a custom experience that's based on your plan, your specific health care needs and lots more. And you can quickly access your digital ID card to show it to your doctor. You can even use **Sydney Health** to track your health goals, find care, compare costs, and manage your claims.

Have a question? **Sydney Health** acts like a personal health guide, answering your questions and connecting you to the right resources at the right time. And you can use the chatbot to get answers quickly. **Sydney Health** makes it easier to get things done, so you can spend more time focusing on your health. Get started by downloading the **Sydney Health** mobile app.

Register for online tools and resources

Accessing your health plan on your mobile phone or computer makes life so much easier. Register on the **Sydney Health** mobile app and **anthem.com** to get personalized information about your health plan and more. You can:

- Quickly access your digital ID card.
- Find a doctor and estimate your costs before you go.
- View your claims, see what's covered and what you may owe for care.
- Get support managing your health conditions and tracking your goals.
- Update your email and communication preferences.

Your Summary of Benefits
POQUOSON CITY PUBLIC SCHOOLS
Anthem Dental Complete

Anthem BlueCross BlueShield
Health · Pharmacy · Dental · Vision · Life · Disability

WELCOME TO YOUR DENTAL PLAN!

This benefit summary outlines how your dental plan works and provides you with a quick reference of your dental plan benefits. For complete coverage details, please refer to your certificate of coverage.

Dental coverage you can count on

Your Anthem dental plan lets you visit any licensed dentist or specialist you want - with costs that are normally lower when you choose one within our large network.

Savings beyond your dental plan benefits - you get more for your money.

You pay our negotiated rate for covered services from in-network dentists even if you exceed your annual benefit maximum.

YOUR DENTAL PLAN AT A GLANCE		In-Network	Out-of-Network
Annual Benefit Maximum	Contract Year		
· Per insured person		**$2,000**	**$2,000**
D&P applies to Annual Maximum		**No**	**No**
Annual Maximum Carryover		**No**	**No**
Orthodontic Lifetime Benefit Maximum			
· Per eligible insured person		**$1,500**	**$1,500**
Annual Deductible (The Deductible does not apply to Orthodontic Services)			
· Per insured person	Contract Year	**$50**	**$50**
· Family maximum		**3X Individual**	**3X Individual**
Deductible Waived for Diagnostic/Preventive Services		**Yes**	**Yes**
Out-of-Network Reimbursement Options:		**Prime (MAC)**	

Dental Services	In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period
Diagnostic and Preventive Services · Periodic oral exam · Teeth cleaning (prophylaxis) · Bitewing X-rays: 1X per 12 months · Intraoral X-rays	100% Coinsurance	100% Coinsurance	No Waiting Period
Basic Services · Amalgam (silver-colored) Filling · Front composite (tooth-colored) Filling · Back composite Filling, Covered as Composites · Simple Extractions	80% Coinsurance	80% Coinsurance	No Waiting Period
Endodontics · Root Canal	80% Coinsurance	80% Coinsurance	No Waiting Period
Periodontics · Scaling and root planing	80% Coinsurance	80% Coinsurance	No Waiting Period
Oral Surgery · Surgical Extractions	80% Coinsurance	80% Coinsurance	No Waiting Period
Major Services · Crowns	50% Coinsurance	50% Coinsurance	No Waiting Period
Prosthodontics · Dentures · Bridges · Dental implants Not Covered	50% Coinsurance	50% Coinsurance	No Waiting Period
Prosthetic Repairs/Adjustments	80% Coinsurance	80% Coinsurance	No Waiting Period
Orthodontic Services ·Dependent Children Only*	50% Coinsurance	50% Coinsurance	No Waiting Periods

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.

*Child orthodontic coverage begins at age eight and runs through age 18. This means that the child must have been banded between the ages of 8 and 19 in order to receive coverage. If children are dependents until age 19, they can continue to receive coverage, but they must have been banded before age 19.

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.

Anthem BlueCross BlueShield
Health · Pharmacy · Dental · Vision · Life · Disability

** The International Emergency Dental Program is managed by DeCare Dental, which is an independent company offering dental-management services to Anthem Blue Cross Life and Health Insurance Company.

Promoting healthy mouths for members who are pregnant or living with diabetes
If you are pregnant or living with diabetes, you can sign up to receive one additional dental cleaning or periodontal maintenance procedure per year.

Finding a dentist is easy.
To select a dentist by name or location:
• Go to anthem.com/mydentalvision or the website listed on the back of your ID card.
• Call the toll-free customer service number listed on the back of your ID card.

TO CONTACT US:

Call	Write
Refer to the toll-free number indicated on the back of your plan 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.	your plan ID card for the address.

Limitations & Exclusions

Limitations – Below is a partial listing of dental plan limitations when these services are covered under your plan. Please see your certificate of coverage for a full list.

Diagnostic and Preventive Services

Oral evaluations (exam) Limited to two per Calendar Year

Teeth cleaning (prophylaxis) Limited to two per Calendar Year

Intraoral X-rays, single film Limited to four films per 12-month period

Complete series X-rays (panoramic or full-mouth) Coverage Every 5 Years

Topical fluoride application Limited to once every 12 months for members through age 18

Sealants Limited to first and second molars once every 24 months per tooth for members through age 15; sealants may be covered under Diagnostic and Preventive or Basic Services.

Basic and/or Major Services***

Fillings Limited to once per surface per tooth in any 24 months

Space Maintainers Limited to extracted primary posterior teeth once per lifetime per tooth for members through age 16; Space Maintainers may be covered under Diagnostic and Preventive or Basic Services.

Crowns Limited to once per tooth in a seven-year period

Fixed or removable prosthodontics – dentures, partials, bridges

Covered once in any seven-year period; benefits are provided for the replacement of an existing bridge, denture or partial for members age 16 or older if the appliance is seven years old or older and cannot be made serviceable.

Root canal therapy Limited to once per lifetime per tooth; coverage is for permanent teeth only.

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

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

Brush Biopsy Standard - Covered

***Waiting periods** for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan.
There is a waiting period of up to 24 months for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

ADDITIONAL LIMITATION FOR ORTHODONTIC SERVICES

Orthodontia Limited to one course of treatment per member per lifetime

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

Services provided before or after the term of coverage

Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate

Orthodontics (unless included as part of your dental plan benefits) 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 third molars (wisdom teeth) that do not exhibit symptoms or impact the oral health of the member

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 Life and Health Insurance Company.

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.

Here's why:

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's 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 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 amount 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 $400 coinsurance, the total he'll pay the out-of-network dentist is $800.
Here's the math:

- Dentist's charge: $1,200
- Anthem's maximum allowed amount: $800
- Anthem pays 50%: $400
- Ted pays 50% (coinsurance): $400
- Balance Ted owes the provider: $1,200 - $800 = $400
- Ted's total cost: $400 coinsurance + $400 provider balance = $800

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.

DENTAL PPO

It's easy to find a dentist online

Here's how to find one fast on our mobile app, Sydney, or anthem.com.

Select *Find a Doctor*	To search on the app, you'll need a username and password. On anthem.com, log in as a member with your username and password, or your member ID card number. You can also search as a guest. Just select a plan or network, or search by all plans and networks.*
Search for a provider	You can search based on type of provider or facility, locations near you or a provider's name.
Click on the name of a dentist to learn more	Find out about their training, specialties, languages spoken, location and phone number.

Keep in mind, you'll get the most from your benefits — and save money — when you use a provider in your plan.

Download our Sydney mobile app today to easily access your plan.

Anthem

Download on the App Store

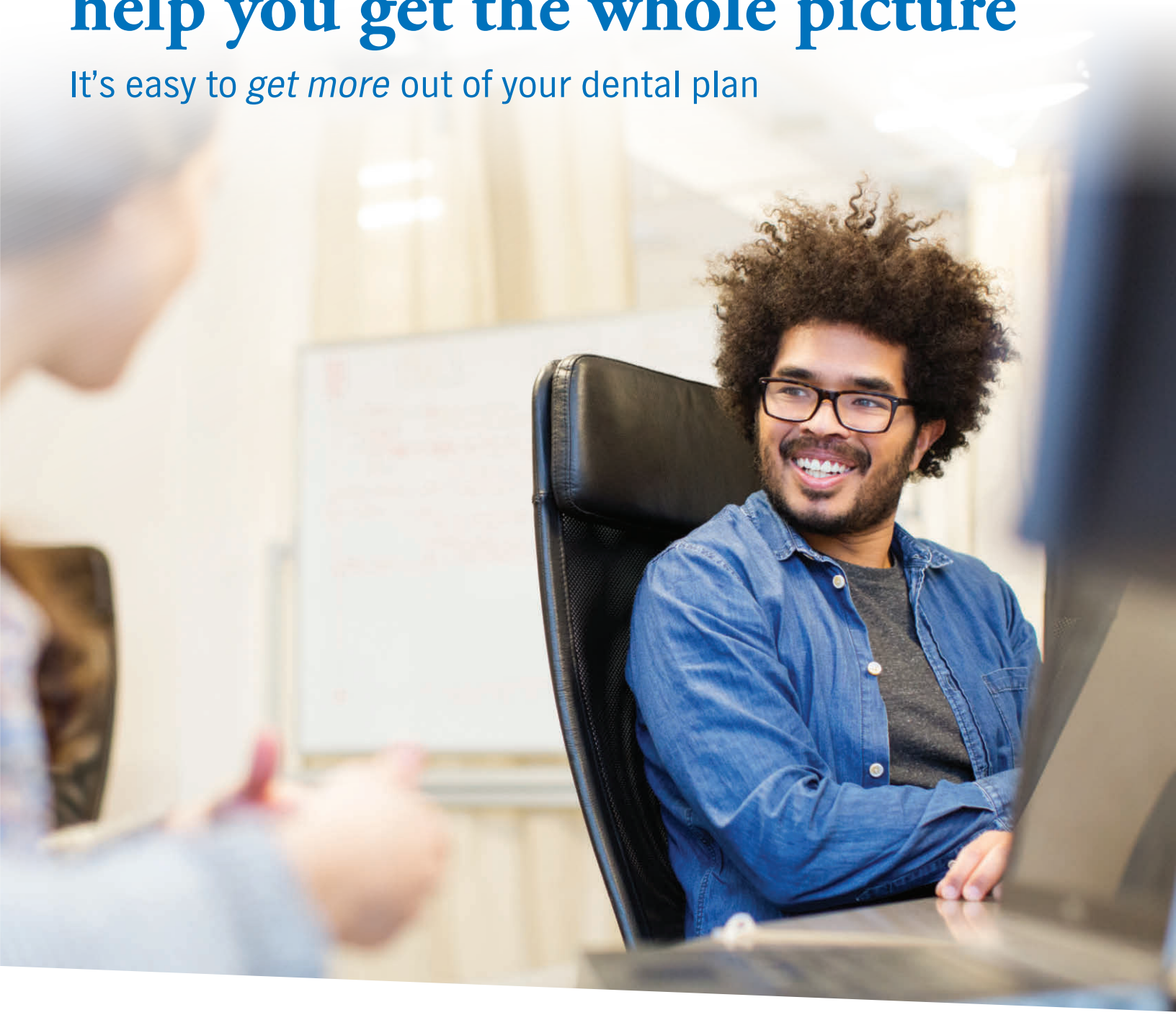
GET IT ON Google Play

* If you don't know the name of your plan or network, check with your human resources department or benefits administrator.

64961MUMENABS_Dental VPOD Rev. 9/19

Online and mobile dental tools help you get the whole picture

It's easy to *get more* out of your dental plan



Anthem

You want to make good dental care decisions. *Smart!*
Your plan has free online dental tools to help you do that.

104466MUMENABS VPOD 6/18

More convenience

So, where do you start? How about with your dental health habits and the **Dental Health Assessment** tool.

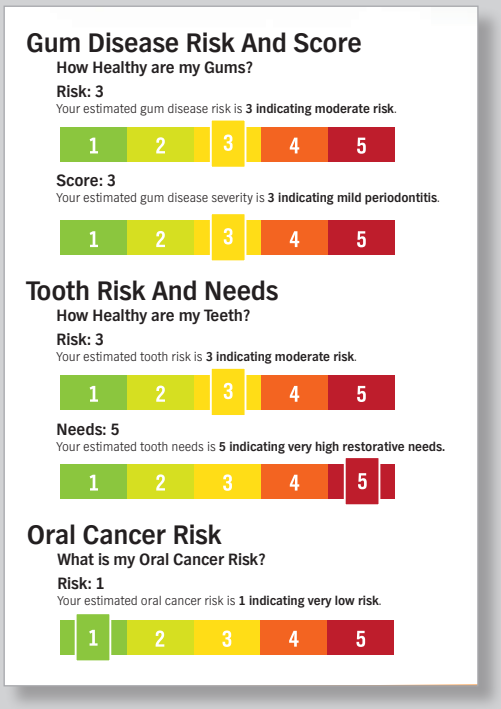
Get your dental health score

Just answer a few online questions about your habits like brushing and flossing and how often you see the dentist. After you do, you'll get an easy-to-follow traffic light scoring report so you know where you stand and what to do about it.

Why? Dental health problems like gum disease are common and can lead to more serious problems, like losing a tooth. Knowing your score helps you understand your dental health and your risk of getting tooth decay, gum disease and mouth cancers. You can even take your report to your next dental appointment.

Check out the easy-to-understand personalized dental report

Log in to the Anthem Member Services website address on your ID card or your Anthem mobile app. Take the **Dental Health Assessment** and discover your dental health score, like this one:



More care

Now you know your dental health score, but you've probably got questions. Where can you get answers?

Ask a Hygienist

You can email **Ask a Hygienist** your dental questions at no extra cost to you. You'll get answers quickly and privately by email in about 24 hours from one of a team of licensed dental professionals with expertise on how to help prevent and treat diseases of the mouth. They can even offer dental health tips.

More savings

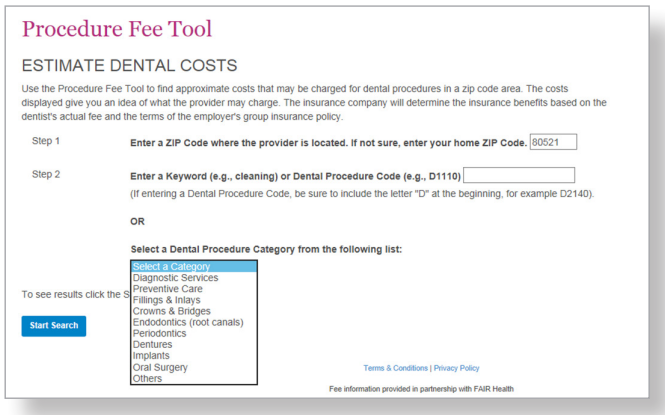
Need dental care? Want to find out what it'll cost before you go?

Help estimating costs ahead of time

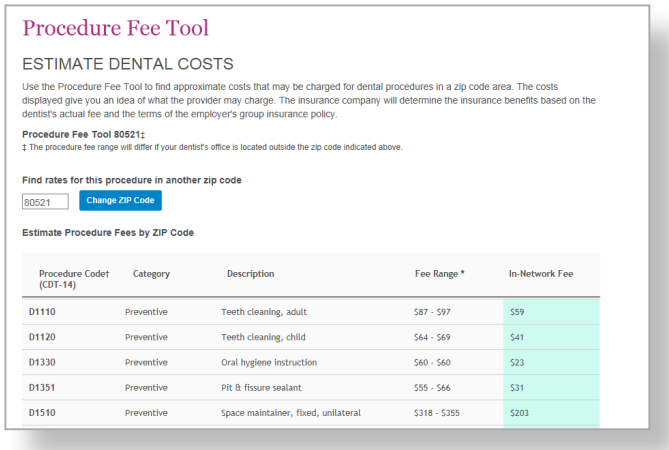
You're careful about what you spend money on — and about saving money, too! So you shop for the best value. With the **Dental Care Cost Estimator** tool, you can estimate the costs for common dental procedures and treatments and compare them for dentists and providers in your network before you get care. That way, you can make informed choices and save money.

Try out the Dental Care Cost Estimator

Just go to the tool and start your search.



Get an estimate for what you'll pay.



Ready to try out these tools?

Log in to the Anthem Member Services website address on your ID card or your Anthem mobile app.

Zoom in to get more:

Care. Convenience. Choices. Savings.

Zoom out for the big picture:

What's going on in your mouth could be a sign for what's going on elsewhere in your body — **90%** of the body's diseases show signs and symptoms in the mouth.*

Your dental plan is about more than teeth.

It's about caring for the whole body. Want to learn more? Log in to the Anthem Member Services website address on your ID card or your Anthem mobile app.

- Find a dentist in your plan.
- Order extra ID cards.
- Get the status of a claim.
- Learn ways to get more from your plan.

* Academy of General Dentistry Know Your Teeth website: InfoBites – Importance of Oral Health to Overall Health (accessed January 10, 2018): knowyourteeth.com.

Anthem

Your mouth may be telling you something

Like what's going on with your overall health

Listen to your mouth: It can tell you a thing or two about the health of your whole body. In fact, when an unhealthy mouth produces bacteria, it can affect everything from the heart to the bloodstream — and even pregnancy.[1]

Did you know that 90% of the body's diseases first show signs and symptoms in the mouth?[2] Take diabetes, for example. Its first symptoms are often seen through problems in the mouth.[1] Research has also shown links between gum disease and these health problems:[1]

- Heart disease
- Stroke
- Osteoporosis
- Low birth weight
- Respiratory infection

There's good news though: It just takes a few simple habits to help keep your mouth healthy.

Checklist for a healthy mouth

- ✓ Limit food and drinks that are high in sugar.
- ✓ Brush with a soft-bristled toothbrush at least two times a day.
- ✓ When you can swing it, brush after meals and snacks, too.
- ✓ Use a toothpaste that has fluoride.
- ✓ Floss once a day.
- ✓ Get cleanings and checkups by a pro — schedule regular dental visits.
- ✓ See a dentist right away if you think you may have gum disease.

See? Pretty simple. And of course we're always here to help.

Visit anthem.com/dentalhealth to learn how our dental programs support total health.

Our legal team wants us to remind you that we're not giving you medical advice here. That's a special conversation between you and your doctor! Our goal is to help you get the most from your health plan. Curious what's covered? Log in to our website to see your personalized benefits.

1 American Dental Association sponsored website, Mouth Healthy: mouthhealthy.org

59758ANMENABS VPOD 04/16

Anthem

When you have diabetes, dental care can be a challenge

These simple tips can help

If you have diabetes, high blood sugar can affect your teeth and gums in more ways than you may realize. So good dental care should be pretty high on your to-do list.

High blood sugar levels increase your risk for:[1]

- **Cavities (tooth decay)**. The higher your blood sugar level, the more sugars, starches and acid can wear away at your teeth and cause plaque, which can lead to cavities.
- **Early gum disease (gingivitis)**. Diabetes makes it harder to fight off bacteria. If plaque builds up, it can harden into tartar which can lead to gums that bleed and become swollen.
- **Advanced gum disease (periodontitis)**. Gum disease can destroy the tissue and bone that support your teeth and can even affect your jawbone. Diabetes also makes it harder to fight off gum infections and heal from gum disease, which can then make diabetes hard to control.

Look for these telltale signs of periodontal disease from diabetes.

See your dentist right away if you have one or more of these symptoms:

- Gums that are: red, sore, swollen or bleeding
- Gums that have pulled away from your teeth (recession)
- Persistent bad breath or bad taste in your mouth
- Heavy deposits of milky white or yellow plaque
- Pus between the teeth and gums (abscess)

Treating gum disease early can save you money.

- Patients with diabetes who treat their gum disease have 39% fewer hospital stays and 40% lower health care costs.[2]
- If you catch a minor dental problem early, you can avoid more costly treatments down the road.

Good dental health is actually pretty simple. (We've got the checklist below to prove it.)

Checklist for a healthy mouth

- ✓ Limit food and drinks that are high in sugar.
- ✓ Brush with a soft-bristled toothbrush at least two times a day.
- ✓ When you can swing it, brush after meals and snacks.
- ✓ Use a toothpaste that has fluoride.
- ✓ Floss once a day.
- ✓ Get cleanings and checkups by a pro — visit your dentist every six months.
- ✓ See a dentist right away if you think you may have gum disease.

We're always here to help.

Visit anthem.com/dentalhealth to learn how our dental programs support total health.

Our legal team wants us to remind you that we're not giving you medical advice here. That's a special conversation between you and your doctor! Our goal is to help you get the most from your health plan. Curious what's covered? Log in to our website to see your personalized benefits.

1 American Journal of Preventive Medicine's Impact of Periodontal Therapy on General Health Study, June 2014 http://www.ajpmonline.org/article/S0749-3797(14)00153-6/abstract
2 Mayo Clinic website: ***Diabetes and dental care: Guide to a healthy mouth*** (accessed April 2016): mayoclinic.org

59757ANMENABS VPOD 04/16

Straighten your smile for less

Get up to a 50% discount on ProClear Aligners from Anthem SpecialOffers

Everyone wants a great smile, but dental and orthodontic treatments can take a lot of time and money. Braces can cost an average of $5,000 or more.*

For some people, clear teeth-straightening aligners that you buy online can be a good lower-cost option instead of the regular wire braces you get through an orthodontist. That's why we're offering you a discount on ProClear™ Aligners through our Anthem SpecialOffers program.

Just log in and save

To get your discount:

- Log in to **anthem.com**.
- Choose **Care**, then **Discounts**.
- Find the link to *ProClear Aligners*.

If you sign up right away, you'll also get a free whitening kit!

Here's what you'll save:

Regular cost of ProClear Aligners	$2,590
Cost to Anthem members	$1,295

That's a 50% discount!

Start working on your smile!

First, you'll take an online test to make sure the aligners are a good option for you. Then, you'll make an impression of your teeth using the kit ProClear Aligners sends you. They'll use that to make aligners just for you and send them to you. You just follow your care plan by changing your aligners when they tell you to.

Anthem SpecialOffers

As an Anthem member, you get SpecialOffers perks and discounts on lots of wellness products and services like ProClear Aligners.

Check SpecialOffers at anthem.com for the latest discounts on things like gym memberships, acupuncture, weight loss programs and LASIK eye surgery.

Anthem

ProClear™ ALIGNERS

IMPORTANT: PROCLEAR ALIGNERS AREN'T COVERED UNDER YOUR ANTHEM DENTAL PLAN.

* American Dental Association. *2016 Survey of Dental Fees.* Fees for comprehensive treatment of adolescents ranged from $4,978 to $6,900. Fees for comprehensive treatment of adults ranged from $5,100 to $7,045.

116441MUMENABS VPOD 7/19

Here's how it works when you have *two* dental plans

You may have a dental plan from your employer and your spouse has one, too. Or if you're divorced, you may be wondering how dental coverage works for your children.

Health and dental plans work together to make sure they're not paying for the same care. This is called coordination of benefits (COB), and it's the way we figure out which plan pays for your dental care. State laws guide which plan pays first — this is called the **primary** plan. The **secondary** plan may also pay, depending on what it covers and how much the primary plan pays. Even if you get benefits from both plans, they may not cover all your costs. The combined benefits should never be more than the cost of your care.

So which plan is primary?

It mostly depends on who's getting the dental care.

If the care is for	Then
You, and you have a dental plan with your employer	**Your plan** is primary
Your spouse, and they also have a dental plan through their employer	**Their plan** is primary
Your child, and you and your spouse each have a dental plan	**The primary plan** is the one for the parent whose birthday comes first in the year
Your child, and you're divorced but the divorce decree makes you responsible for your child's health care costs	**Your plan** is primary
Your child, and you're divorced but the divorce decree doesn't name who's responsible for health care costs	**The plan of the parent with custody of the child** is usually primary*

There's an exception to these rules. If you and your spouse each have a dental plan and one of the plans doesn't coordinate benefits, that plan is primary for both of you. Check your spouse's dental plan to find out.

What does the primary plan pay?

The primary plan pays the full benefit allowed by the plan as if you had no other coverage. Based on how much your primary plan pays and what it covers, the secondary plan may also kick in.

Questions?

Call the Member Services number on the back of your ID card. We're here to help.

Anthem

114531MUMENABS VPOD 04/19

How does the secondary plan work?

Any payments the secondary plan makes are based on the balance after the primary plan pays. And then, the secondary plan pays only toward the services it covers and only the amounts it allows for those services. If the amount it allows for a service is lower than what the primary plan pays, the secondary plan doesn't pay.

Secondary plan payments are decided either by:

- Standard method: The primary plan payment plus the secondary plan payment can't be more than 100% of the submitted charges.
- Non-duplication of benefits method: The secondary plan doesn't pay any more on the claim than it would have paid if it were the primary plan.

Here are some examples showing how these payment methods work for dental and orthodontic care. Remember, these are just examples. Your plan payments won't be exactly like this.

Dental

Standard method		Non-duplication of benefits method	
Primary		**Primary**	
Billed amount	$550	Billed amount	$550
Allowed amount	$550	Allowed amount	$550
Deductible	$50	Deductible	$50
Allowed amount less deductible	$500	Allowed amount less deductible	$500
50% coverage	$250 ($500 x 50%)	50% coverage	$250 ($500 x 50%)
Primary plan pays	$250	Primary plan pays	$250
Secondary		**Secondary**	
Billed amount	$550	Billed amount	$550
Allowed amount	$550	Allowed amount	$550
Deductible	$50	Deductible	$50
Allowed amount less deductible	$500	Allowed amount less deductible	$500
80% coverage	$400 ($500 x 80%)	80% coverage	$400 ($500 x 80%)
(Primary plan paid)	$250	(Primary plan paid)	$250
Secondary plan pays	$300 ($550 - $250)	Secondary plan pays	$150 ($400 - $250)
You pay	$0	You pay	$150

Note: This example shows payments based on the primary dental plan paying 50% of allowed dental costs and the secondary dental plan paying 80% of allowed dental costs. Your plans may cover different amounts.

Orthodontics

Standard method		Non-duplication of benefits method	
Primary		**Primary**	
Billed amount	$5,250	Billed amount	$5,250
Allowed amount	$5,250	Allowed amount	$5,250
50% coverage	$2,625 ($5,250 x 50%)	50% coverage	$2,625 ($5,250 x 50%)
Primary plan pays	$1,000 (assumes plan includes $1,000 lifetime maximum)	Primary plan pays	$1,000 (assumes plan includes $1,000 lifetime maximum)
Secondary		**Secondary**	
Billed amount	$5,250	Billed amount	$5,250
Allowed amount	$5,250	Allowed amount	$5,250
50% coverage	$2,625 ($5,250 x 50%)	50% coverage	$2,625 ($5,250 x 50%)
Secondary plan pays	$1,000 (assumes plan includes $1,000 lifetime maximum)	Secondary plan pays	$0
You pay	$3,250	You pay	$4,250

Note: This example shows payments based on the primary and secondary dental plans paying 50% of allowed orthodontic costs. It also assumes the plans have a $1,000 lifetime maximum orthodontic benefit. This may not be the case with your plans.

*If your divorce decree doesn't name the parent responsible for your child's health care expenses, the primary plan is determined in this order: 1) plan of the parent with custody of the child; 2) plan of the spouse of the parent with custody of the child; 3) plan of the parent who doesn't have custody of the child.

Coordination of benefits isn't calculated based on pre-estimates for services. There is no guarantee that the primary plan will pay the pre-estimate amount when the claim is actually processed.

This is a summary of only a few of the provisions of your dental plans to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and doesn't change or replace the language contained in your insurance plan, which determines your benefits. For more information, please contact your insurance company customer service department or your human resources department.

Anthem does not determine whether a service submitted for payment or benefit under this Certificate is a Dental Procedure that is dentally necessary to treat a specific condition or restore dentition for an individual. The Plan evaluates Dental Procedures submitted to determine if the procedure is a covered benefit. Your coverage includes a preset schedule of Dental Services that are eligible for benefit by Anthem. Other Dental Services may be recommended or prescribed by your Dentist which are dentally necessary, offer you an enhanced cosmetic appearance, or are more frequent than covered by Anthem. While these services may be prescribed by your Dentist and are dentally necessary for you, they may not be a Dental Service that is benefited by Anthem or they may be a service where Anthem provides a payment allowance for a service that is considered to be optional treatment. If Anthem gives you a payment allowance for optional treatment that is covered, you may apply this Anthem payment to the service prescribed by your Dentist which you elected to receive. Services that are not covered by Anthem or exceed the frequency of plan benefits do not imply that the service is or is not dentally necessary to treat your specific dental condition. You are responsible for Dental Services that are not covered or benefited by Anthem. Determination of services necessary to meet your individual dental needs is between you and your Dentist.

ONLY those services listed below are covered. Deductibles and Dental Benefit Maximums are listed under the Summary of Benefits. Covered Services are subject to the limitations within the Benefits, Exclusions and Limitations sections described below. For estimates of Covered Services, please see the "Pretreatment Estimate" section of this Certificate.

PREVENTIVE CARE
(Diagnostic & Preventive Services)

Oral Evaluations - Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

NOTE: Comprehensive oral evaluations will be benefited 1 time per dental office, subject to the 2 times per calendar year limitation. Any additional comprehensive oral evaluations performed by the same dental office will be benefited as a periodic oral evaluation and will be subject to the 2 times per calendar year limitation.

Radiographs (X-rays)

- **Bitewings** - Covered at 1 series of bitewings per 12-month period.
- **Full Mouth (Complete Series) or Panoramic** - Covered 1 time per 60-month period.
- **Periapical(s)** - 4 single x-rays are covered per 12-month period.
- **Occlusal** - Covered at 2 series per 24-month period.

Dental Cleaning

- **Prophylaxis** - Any combination of this procedure or periodontal maintenance (see Periodontics section) is covered 2 times per calendar year.

  Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

  NOTE: A prophylaxis performed on a Member under the age of 14 will be benefited as a child prophylaxis. A prophylaxis performed on a Member age 14 or older will be benefited as an adult prophylaxis.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered 1 time per 24-month period for permanent first and second molars of eligible dependent children through the age of 15.

Fluoride Treatment (Topical application of fluoride) - Covered 1 time per 12-month period for dependent children through the age of 18.

EXCLUSIONS - Coverage is NOT provided for:

1. Oral hygiene instructions.
2. Amalgam or composite restorations placed for preventive or cosmetic purposes.

BASIC SERVICES

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Restorations

- **Amalgam (silver) Restorations** - Treatment to restore decayed or fractured permanent or primary teeth.

- **Composite (white) Resin Restorations**
  - **Anterior (front) Teeth** - Treatment to restore decayed or fractured permanent or primary anterior (front) teeth.
  - **Posterior (back) Teeth** - Treatment to restore decayed or fractured permanent or primary posterior (back) teeth.

  LIMITATION: Coverage for amalgam or composite restorations shall be limited to only 1 service per tooth surface per 24-month period.

Space Maintainers - Covered 1 time per lifetime on eligible dependent children through the age of 16 for extracted primary posterior (back) teeth.

LIMITATION: Repair or replacement of lost/broken appliances are not a covered benefit.

Basic Tooth Extractions
- Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Restorative cast post and core build-up, including pins and posts - See benefit coverage description under Complex or Major Restorative Services.

Brush Biopsy - Covered 1 time per 36-month period, per Member age 20 to 39. Covered 1 time per 12-month period per Member age 40 and above.

EXCLUSIONS - Coverage is NOT provided for:

1. Case presentation and office visits.
2. Athletic mouthguard, enamel microabraision, and odontoplasty.
3. Services or supplies that have the primary purpose of improving the appearance of the teeth. This includes but is not limited to whitening agents, tooth bonding and veneers.
4. Placement or removal of sedative filling, base or liner used under a restoration.

5. Pulp vitality tests.
6. Diagnostic and adjunctive diagnostic casts.

BASIC ENDODONTIC SERVICES (NERVE OR PULP TREATMENT)

Endodontic Therapy on Primary Teeth
- **Pulpal Therapy**
- **Therapeutic Pulpotomy**

Endodontic Therapy on Permanent Teeth
- **Root Canal Therapy**

LIMITATION: All of the above procedures are covered 1 time per tooth per lifetime.

EXCLUSIONS - Coverage is NOT provided for:

1. Retreatment of endodontic services that have been previously benefited under this Certificate.
2. Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
3. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
4. Intentional reimplantation.
5. Apicoectomy.
6. Root Amputation.
7. Apexification.
8. Retrograde filling.
9. Hemisection.

PERIODONTICS (GUM & BONE TREATMENT)

Periodontal Maintenance - A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

LIMITATION: Any combination of this procedure and dental cleanings (see Diagnostic and Preventive section) is covered 2 times per calendar year.

Basic Non Surgical Periodontal Care - Treatment of diseases of the gingival (gums) and bone supporting the teeth.
- **Periodontal scaling & root planing** - Covered 1 time per 36 months if the tooth has a pocket depth of 4 millimeters or greater.
- **Full mouth debridement** - Covered 1 time per lifetime.

Complex Surgical Periodontal Care - Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services under this plan.
- **Gingivectomy/gingivoplasty;**
- **Gingival flap;**
- **Apically positioned flap;**

- **Osseous surgery;**
- **Bone replacement graft;**
- **Pedicle soft tissue graft;**
- **Free soft tissue graft;**
- **Subepithelial connective tissue graft;**
- **Soft tissue allograft;**
- **Combined connective tissue and double pedicle graft;**
- **Distal/proximal wedge - LIMITATION: Covered on natural teeth only.**

LIMITATION: Only 1 complex surgical periodontal service is a benefit covered 36-month period per single tooth or multiple teeth in the same quadrant and only if the pocket depth of the tooth is 5 millimeters or greater.

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as crown lengthening.
2. Bacteriologic tests for determination of periodontal disease or pathologic agents.
3. The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
4. Provisional splinting, temporary procedures or interim stabilization of teeth.
5. Analgesia, analgesic agents, anxiolysis, inhalation of nitrous oxide or therapeutic drug injections, drugs, or medicaments for non-surgical and surgical periodontal care, regardless of the method of administration.

ORAL SURGERY (TOOTH, TISSUE, OR BONE REMOVAL)

Complex Surgical Extractions
- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

LIMITATION: Surgical removal of 3rd molars are only covered if the removal is associated with symptoms or oral pathology.

Other Complex Surgical Procedures
- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis - per site
- Surgical reduction of osseous tuberosity

LIMITATION: The Other Complex Surgical Procedures are covered only when required to prepare for dentures and is a benefit covered once in a 60-month period.

Surgical Reduction of Fibrous Tuberosity - Covered 1 time per 6-month period.

Intravenous Conscious Sedation, IV Sedation and General Anesthesia - Covered when performed in conjunction with complex surgical service.

LIMITATION: Intravenous conscious sedation, IV sedation and general anesthesia will not be covered when performed with non-surgical dental care.

Temporomandibular Joint Disorder (TMJ)

Dental treatment that is considered surgical and nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder, including splints, is subject to the coordination of benefits. A Pre-treatment Estimate of Benefits is recommended. NOTE: If you or your dependents currently have medical insurance coverage, the claim must be first submitted to that medical insurance program. Any remaining costs after consideration under your medical insurance may be submitted to the Plan for further benefit (see Coordination of Benefits). You must submit a copy of the medical Explanation of Benefits (EOB) along with your claim to the Plan.

If you or your dependents are not eligible for TMJ benefits under another insurance program, either medical or dental, dental services for TMJ will be covered under this plan within the noted plan limitations, maximums, deductibles and payment percentages of treatment costs.

LIMITATIONS

1. Reconstructive Surgery benefits shall be provided for reconstructive surgery when such dental procedures are incidental to or follows surgery resulting from injury, illness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, however that such procedures are dental reconstructive surgical procedures.
2. Inpatient or outpatient dental expenses arising from dental treatment up to age 18, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate.

   For programs without orthodontic coverage: Dental orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this dental benefit plan.

   For programs with orthodontic coverage: If coverage for the treatment of cleft lip or cleft palate is available under any other policy or contract of insurance, this plan shall be primary and the other policy or contract shall be secondary.

EXCLUSIONS - Coverage is NOT provided for:

1. Intravenous conscious sedation, IV sedation and general anesthesia when performed with non-surgical dental care.
2. Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration.
3. Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
4. Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants.
5. Implant maintenance or repair to an implant or implant abutment.
6. Surgical exposure of impacted or unerupted tooth for orthodontic reasons.
7. Any oral surgery except for simple and surgical extractions.
8. Surgical repositioning of teeth.
9. Inpatient or outpatient hospital expenses.
10. Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.

COMPLEX OR MAJOR RESTORATIVE SERVICES (CROWNS, INLAYS AND ONLAYS)
Services performed to restore lost tooth structure as a result of decay or fracture

Gold foil restorations - Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances. The patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Services and optional treatment, plus any Deductible and/or Coinsurance for the covered benefit. Covered 1 time per 24-month period.

Inlays - Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

LIMITATION: If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and optional treatment, plus any Deductible and/or Coinsurance for the Covered Service.

Pre-fabricated or Stainless Steel Crown - Covered 1 time per 60-month period for eligible dependent children through the age of 18.

Onlays and/or Permanent Crowns - Covered 1 time per 7 year period per tooth for Members age 12 and older if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth.

LIMITATION: Porcelain/ceramic substrate onlays/crowns - Benefits will be limited to the Maximum Allowed Amount for a porcelain to noble metal crown. The patient must pay the difference in cost between the allowed fee for the Covered Service and optional treatment, plus any Deductible and/or Coinsurance for the covered benefit.

Implant Crowns - See Prosthetic Services.

Recement Inlay, Onlay and Crowns - Covered 6 months after initial placement.

Crown Repair - Covered 1 time per 12-month period per tooth when the submitted narrative from the treating dentist supports the procedure.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface - Covered 1 time per 7 year period when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
2. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
3. Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
4. Placement or removal of sedative filling, base or liner used under a restoration.
5. Canal prep & fitting of preformed dowel & post.
6. Temporary, provisional or interim crown.
7. Occlusal procedures.

8. Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.

PROSTHETIC REPARIS AND ADJUSTMENT SERVICES (DENTURES, PARTIALS, AND BRIDGES)

Tissue Conditioning - Covered 1 time per 24-month period.

Recement Fixed Prosthetic - Covered 1 time per 12-month period.

Reline and Rebase - Covered 1 per 24-month period:

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) - Covered 1 per 6-month period:

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge); and
- when the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments - Covered 2 times per 12-month period:

- when the denture is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the denture.

Partial and Bridge Adjustments - Covered 2 times per 24-month period:

- when the partial or bridge is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the partial or bridge.

EXCLUSIONS - Coverage is NOT provided for:

1. The replacement of an existing partial denture with a bridge.
2. Initial installation of full or partial dentures, implants or fixed bridgework to replace a tooth (teeth) which was extracted prior to becoming a Member under this plan. EXCEPTION: This exclusion shall not apply for any person who has been continuously covered under this plan for more than 24 months.
3. Coverage for congenitally missing teeth. EXCEPTION: This exclusion shall not apply for any person who has been continuously covered under this dental benefit plan for more than 24 months.
4. Interim removable or fixed prosthetic appliances (dentures, partials or bridges).
5. Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
6. Additional, elective or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments.
7. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
8. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
9. Services or supplies that have the primary purpose of improving the appearance of your teeth.

10. Placement or removal of sedative filling, base or liner used under a restoration.
11. Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants.
12. Implant maintenance or repair to an implant or implant abutment.
13. Coverage shall be limited to the least expensive professionally acceptable treatment.

PROSTHETIC SERVICES (DENTURES, PARTIALS, AND BRIDGES)

Removable Prosthetic Services (Dentures and Partials) - Covered 1 time per 7 year period:

- for Members age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if 7 years have elapsed since the last benefited removable prosthetic appliance (denture or partial) and the existing denture or partial needs replacement because it cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) - Covered 1 time per 7 year period:

- for Members age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if no more than 3 teeth are missing in the same arch;
- a natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- no other missing teeth in the same arch that have not been replaced with a removable partial denture;
- if none of the individual units of the bridge has been benefited previously as a crown or cast restoration in the last 7 years;
- if 7 years have elapsed since the last benefited removable prosthetic appliance (bridge) and the existing bridge needs replacement because it cannot be repaired or adjusted.

LIMITATION: If there are multiple missing teeth, a removable partial denture may be the benefit since it would be the least costly, commonly performed course of treatment. Please refer to the Optional Treatment Plans section. The optional benefit is subject to all contract limitations on the benefited service.

Implant Supported Fixed and Removable Prosthetic (Crowns, Bridges, Partials and Dentures) - A restoration that is retained, supported and stabilized by an implant. Implants and related services are NOT covered.

LIMITATION: This procedure receives an optional treatment benefit equal to the least expensive professionally acceptable treatment. The additional fee is the patient's responsibility. For example: A single crown to restore one open space will be given the benefit of a Fixed Partial Denture Pontic (one unit). The optional benefit is subject to all contract limitations on the Covered Service.

EXCLUSIONS - Coverage is NOT provided for:

1. The replacement of an existing partial denture with a bridge.
2. Initial installation of full or partial dentures, implants or fixed bridgework to replace a tooth (teeth) which was extracted prior to becoming a Member under this plan. EXCEPTION: This exclusion shall not apply for any person who has been continuously covered under this plan for more than 24 months.
3. Coverage for congenitally missing teeth. EXCEPTION: This exclusion shall not apply for any person who has been continuously covered under this dental benefit plan for more than 24 months.

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4. Interim removable or fixed prosthetic appliances (dentures, partials or bridges).
5. Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
6. Additional, elective or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments.
7. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
8. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
9. Services or supplies that have the primary purpose of improving the appearance of your teeth.
10. Placement or removal of sedative filling, base or liner used under a restoration.
11. Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants.
12. Implant maintenance or repair to an implant or implant abutment.
13. Coverage shall be limited to the least expensive professionally acceptable treatment.

ORTHODONTICS

TREATMENT NECESSARY FOR THE PREVENTION AND CORRECTION OF MALOCCLUSION OF TEETH AND ASSOCIATED DENTAL AND FACIAL DISHARMONIES.

Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.

Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.

Comprehensive (complete) Treatment - Full treatment includes all records, appliances and visits.

Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.

Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.

Other Complex Surgical Procedures

- **Surgical exposure of impacted or unerupted tooth for orthodontic reasons**
- **Surgical repositioning of teeth**

LIMITATION: Treatment in progress (appliances placed prior to eligibility under this plan) will be benefited on a pro-rated basis.

LIMITATION: Covered eligible dependent children from the age of 8 through the age of 18.

EXCLUSIONS - Coverage is NOT provided for:
1. Monthly treatment visits that are inclusive of treatment cost;
2. Repair or replacement of lost/broken/stolen appliances;
3. Orthodontic retention/retainer as a separate service;
4. Retreatment and/or services for any treatment due to relapse;
5. Inpatient or outpatient hospital expenses; and
6. Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments: Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. The Member must have continuous eligibility under the plan in order to receive ongoing orthodontic benefit payments.

Benefit payments are made in equal amounts: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or until the lifetime maximum benefits are exhausted (see Benefit Maximums in the Summary of Benefits).

Before treatment begins, the treating dentist should submit a Pre-treatment Estimate. An Estimate of Benefits form will be sent to you and your dentist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the dentist should submit the Estimate of Benefit form with the date of placement and his/her signature. After benefit and eligibility verification by the Plan, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be issued to you and your dentist. This again will serve as the claim form to be submitted 6 months from the date of appliance placement.

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese
您有權免費獲得透過您使用的語言提供的幫助。請撥打您的 ID 卡片上的會員服務電話號碼。若您是視障人士，還可索取本文件的其他格式版本。

Vietnamese
Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

Korean
귀하는 자국어로 무료지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

Tagalog
May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

Russian
Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

Armenian
Դուք իրավունք ունեք ստանալ անվճար օգնություն ձեր լեզվով: Պարզապես զանգահարեք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

Farsi
"شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید." دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید.

French
Vous pouvez obtenir gratuitement de l'aide dans votre langue. Il vous suffit d'appeler le numéro réservé aux membres qui figure sur votre carte d'identification. Si vous êtes malvoyant, vous pouvez également demander à obtenir ce document sous d'autres formats.

Arabic
لك الحق في الحصول على مساعدة بلغتك مجانًا. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

Japanese
お客様の言語で無償サポートを受けることができます。IDカードに記載されているメンバーサービス番号までご連絡ください。

Haitian
Se dwa ou pou w jwenn èd nan lang ou gratis. Annik rele nimewo Sèvis Manm ki sou kat ID ou a. Èske ou gen pwoblèm pou wè? Ou ka mande dokiman sa a nan lòt fòma tou.

Italian
Ricevere assistenza nella tua lingua è un tuo diritto. Chiama il numero dei Servizi per i membri riportato sul tuo tesserino. Sei ipovedente? È possibile richiedere questo documento anche in formati diversi

Polish
Masz prawo do uzyskania darmowej pomocy udzielonej w Twoim języku. Wystarczy zadzwonić na numer działu pomocy znajdujący się na Twojej karcie identyfikacyjnej.

Punjabi
ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਬਸ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਸਿਰਵਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ? ਤੁਸ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. 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 in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to 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. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

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The legal stuff we're required to tell you

How we keep your information safe and secure

As a member, you have the right to expect us to protect your personal health information. We take this responsibility very seriously, following all state and federal laws, as well as our own policies.

You also have certain rights and responsibilities when receiving your health care. To learn more about how we protect your privacy, your rights and responsibilities when receiving health care, and your rights under the Women's Health and Cancer Rights Act, go to **anthem.com/privacy**. For a printed copy, please contact your Benefits Administrator or Human Resources representative.

How we help manage your care

To see if your health benefits will cover a treatment, procedure, hospital stay or medicine, we use a process called utilization management (UM). Our UM team is made up of doctors and pharmacists who want to be sure you get the best treatments for certain health conditions. They review the information your doctor sends us before, during or after your treatment. We also use case managers. They're licensed health care professionals who work with you and your doctor to help you manage your health conditions. They also help you better understand your health benefits.

To learn more about how we help manage your care, go to **anthem.com/memberrights**. To request a printed copy, please contact your Benefits Administrator or Human Resources representative.

Special enrollment rights

Open enrollment usually happens once a year. That's the time you can choose a plan, enroll in it or make changes to it. If you choose not to enroll, there are special cases when you're allowed to enroll during other times of the year.

- **If you had another health plan that was canceled**. If you, your dependents or your spouse are no longer eligible for benefits with another health plan (or if the employer stops contributing to that health plan), you may be able to enroll with us. You must enroll within 31 days after the other health plan ends (or after the employer stops paying for the plan). For example: You and your family are enrolled through your spouse's health plan at work. Your spouse's employer stops paying for health coverage. In this case, you and your spouse, as well as other dependents, may be able to enroll in one of our plans.
- **If you have a new dependent**. You gain new dependents from a life event like marriage, birth, adoption or if you have custody of a minor and an adoption is pending. You must enroll within 31 days after the event. For example: If you got married, your new spouse and any new children may be able to enroll in a plan.
- **If your eligibility for Medicaid or SCHIP changes**. You have a special period of 60 days to enroll after:
  - You (or your eligible dependents) lose Medicaid or the State Children's Health Insurance Program (SCHIP) benefits because you're no longer eligible.
  - You (or eligible dependents) become eligible to get help from Medicaid or SCHIP for paying part of the cost of a health plan with us.

Get the full details

Read your ***Certificate of Coverage***, which spells out all the details about your plan. You can it find on **anthem.com**.

Notes

Ready to choose your plan?

Stay tuned, your Benefits Administrator or Human Resources Representative will contact you soon with specific enrollment instructions for your organization. Then just follow those steps to join one of our plans.

Ready to use your plan?

Get some extra help

If you have questions, it's easy to get answers. Contact us through our online Message Center or call the Member Services number on your ID card.

Anthem

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