

# Group Quote Request Form – Dual Choice



Broker name		Broker number		Date submitted	Requested effective date
Type <input type="checkbox"/> New <input type="checkbox"/> Change <input type="checkbox"/> Reinstatement		Current carrier		Association	
Broker fax number		Broker phone number/email		Rates: <input type="checkbox"/> Composite <input type="checkbox"/> Age/Sex	
Group address		City, State, ZIP code		Type of industry	SIC code
		Group name/group number		Group contact name/phone no.	

## Blue Cost Share Options (group size 10-50)

		Network							Non-Network			Prescription Drug	
		Physician Home and Office Services PCP/SCP	Deductible Single/Family	Inpatient Facility	Outpatient Surgery: Hospital/Alternative Care Facility	Other Outpatient Services*	Inpatient/Outpatient Professional Services	Out-of-Pocket Maximum Single/Family	Emergency Room Services @ Hospital	Deductible Single/Family	Covered Services Co-insurance unless otherwise stated	Out-of-Pocket Maximum Single/Family	Network Retail Pharmacy
Option 1 <input type="checkbox"/>	HMO	\$15	\$250/\$750	20%	20%	20%	20%	\$2,000/\$4,000	\$150/20%	N/A	N/A	N/A	\$10/\$25/\$40
	PPO	\$15/\$15	\$250/\$750	10%	10%	10%	10%	\$1,500/\$3,000	\$150/10%	\$500/\$1,500	30%	\$3,000/\$6,000	\$10/\$25/\$40
Option 2 <input type="checkbox"/>	HMO	\$15	\$250/\$750	20%	20%	20%	20%	\$2,000/\$4,000	\$150/20%	N/A	N/A	N/A	\$10/\$25/\$40
	PPO	\$20/\$20	\$1,000/\$3,000	20%	20%	20%	20%	\$4,000/\$8,000	\$150/20%	\$2,000/\$6,000	40%	\$8,000/\$16,000	\$10/\$30/\$60
Option 3 <input type="checkbox"/>	HMO	\$10	\$100/\$300	20%	20%	20%	20%	\$1,000/\$2,000	\$150	N/A	N/A	N/A	\$10/\$25/\$40
	PPO	\$15/\$15	\$250/\$750	10%	10%	10%	10%	\$1,500/\$3,000	\$150/10%	\$500/\$1,500	30%	\$3,000/\$6,000	\$10/\$25/\$40
Option 4 <input type="checkbox"/>	HMO	\$10	\$100/\$300	20%	20%	20%	20%	\$1,000/\$2,000	\$150	N/A	N/A	N/A	\$10/\$25/\$40
	PPO	\$15/\$15	\$250/\$750	20%	20%	20%	20%	\$1,500/\$3,000	\$150/20%	\$500/\$1,500	40%	\$3,000/\$6,000	\$10/\$25/\$40
Option 5 <input type="checkbox"/>	HMO	\$10	\$100/\$300	20%	20%	20%	20%	\$1,000/\$2,000	\$150	N/A	N/A	N/A	\$10/\$25/\$40
	PPO	\$15/\$15	\$200/\$600	10%	10%	10%	10%	\$1,000/\$2,000	\$150/10%	\$400/\$1,200	30%	\$2,000/\$4,000	\$10/\$24/\$40

**Participation Guidelines:** Dual Choice (HMO and PPO) must have 10 or more enrolled employees; 20 percent must be enrolled in the plan with the lowest enrollment. Anthem may terminate the plan with the lowest enrollment with 30 days written notice.

Movement between plans will be limited to the period of 60 days before the anniversary date and up to the anniversary date. The change will be effective on the anniversary date.

All other group underwriting guidelines will apply.

### Notes:

- Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance. However, the deductible does not apply to **Emergency Room Services @ Hospital** where a (%) coinsurance may apply to other covered services.
- Physician Home and Office Services exclude certain diagnostic tests such as MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds and Allergy Testing.
- All Mammograms (routine or non-routine), Diabetic Education and Medical Nutritional Therapy at a Network Outpatient Facility are paid at the Physician Home and Office Services PCP copayment. Medical Nutritional Therapy is not covered Non-Network. (Non-network does not apply to HMO).
- Allergy injections -- \$5 copayment Network.
- Specialist (SCP) copayment is applicable to all Specialists (excludes: General Physicians, Internists, Pediatricians, OB/Gyns, Geriatrics or any other Network provider as allowed by the plan). Applies to PPO only.
- Urgent Care Facility (Network and Non-Network if applicable): \$50 copayment.
- N/A means not applicable

\*Other Outpatient Services include, but are not limited to, Allergy Testing, Physical Medicine Therapy through Day Rehabilitation programs, Ambulance Service (PPO only), DME, Home Care Services (including Private Duty Nursing), Hospice Care, MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies and Ultrasounds.

### RX Notes:

Cost share structure equals tier 1/tier 2/tier 3/tier 4

- 30 day supply for Network and Non-network pharmacy( if applicable) does not include drugs obtained through mail service pharmacy
- Certain diabetic and asthmatic supplies, excluding test strips, have no deductible/copayment/coinsurance up to the maximum allowable amount at Network pharmacies. (not covered at Non-network pharmacies.) Diabetic test strips paid same as any other drug. (Network and Non-network if applicable).

This benefit description is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

## Group Name:

### All HMO Health Options include the following (except as noted):

- All medical deductibles, percentage (%) coinsurance and copayments apply toward the out-of-pocket maximum, except for prescription drugs and flat dollar copayments for preventive care services, physician home and office services and urgent care.
- No lifetime maximum
- Benefit period = calendar year.
- Ambulance: No deductible/copayment/coinsurance up to the maximum allowable amount.

#### Skilled Nursing Facility

Limited to 90 days per calendar year

#### Home Care Services:

Limited to 90 visits per calendar year (excludes Private Duty Nursing)

Private Duty Nursing – limited to \$50,000 annually with a lifetime maximum of \$100,000.

#### Durable Medical Equipment and Orthotics:

Subject to benefit maximum of \$4,000 per calendar year (excluding Prosthetic Devices and Medical Supplies).

Prosthetic Devices \$4,000 limit applies per calendar year.

#### Physical Medicine and Rehabilitation:

Limited to 60 days per calendar year, includes Day Rehabilitation programs.

#### Outpatient Therapy:

Physical Therapy: 20 visits

Occupational Therapy: 20 visits

Manipulation Therapy: 12 visits

Speech Therapy: 20 visits

#### Behavioral Health Services:

Mental Health/Substance Abuse

*(Inpatient):* 30

*(Outpatient):* 30 visits

Inpatient and outpatient substance abuse rehabilitation programs are limited to two per lifetime

*(Network and Non-Network combined).*

#### Human Organ and Tissue Transplants:

No deductible/copayment/coinsurance up to the maximum allowable amount.

Kidney and cornea transplants are paid the same as any other medical covered benefit.

#### Prescription Drugs:

Mail Service: 90-day supply

\$20/\$65/\$100 copayments

### All PPO Health Options include the following (except as noted):

- All medical deductibles and percentage (%) coinsurance apply toward the out-of-pocket maximum (i.e., flat dollar copayments and **Non-Network** Human Organ and Tissue Transplant (HOTT) Services are excluded).
- **Network and Non-Network** deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- \$5 million lifetime maximum for all covered medical services (**Network and Non-Network combined**). However, once the medical lifetime maximum is met, no additional prescription drug claims will be paid.
- Benefit period = calendar year.
- Ambulance, Hospice and Urgent Care paid at the **Network** level.

#### Skilled Nursing Facility (**Network and Non-network combined**):

Limited to 90 days per calendar year

#### Home Care Services (**Network and Non-network combined**):

Limited to 90 visits per calendar year (excludes Private Duty Nursing)

Private Duty Nursing – limited to \$50,000 annually with a lifetime maximum of \$100,000.

#### Durable Medical Equipment and Orthotics (**Network and Non-network combined**):

Subject to benefit maximum of \$4,000 per calendar year (excluding Prosthetic Devices and Medical Supplies).

Prosthetic Devices \$4,000 limit applies per calendar year.

#### Physical Medicine and Rehabilitation (**Network and Non-network combined**):

Limited to 60 days per calendar year, includes Day Rehabilitation programs.

#### Outpatient Therapy (**Network and Non-network combined**):

Physical Therapy: 20 visits

Occupational Therapy: 20 visits

Manipulation Therapy: 12 visits

Speech Therapy: 20 visits

#### Behavioral Health Services:

Mental Health/Substance Abuse (**Network**):

*(Inpatient):* 30 days (includes **Non-Network** inpatient mental health)

*(Outpatient):* 30 visits

#### Mental Health/Substance Abuse Limits (**Non-Network**):

- Inpatient mental health combined with Network day limits.
- Outpatient mental health is limited to 10 visits per calendar year.
- Combined inpatient and outpatient substance abuse is limited to \$550 per calendar year.
- Inpatient and outpatient substance abuse rehabilitation programs are limited to two per lifetime (**Network and Non-Network combined**).

#### Human Organ and Tissue Transplants:

**(Network):** No deductible/copayment/coinsurance up to the maximum allowable amount.

**(Non-network):** 50% coinsurance. Does not apply to out-of-pocket maximums. Kidney and cornea transplants are paid the same as any other medical covered benefit.

#### Prescription Drugs:

##### Retail Pharmacy

**Non-network:** 50% copayment with a minimum of the non-preferred tier 3 copayment

Mail Service: 90-day supply

**Network:** \$20/\$65/\$100 copayments except option 2 is \$20/\$75/\$150

**Non-network:** Not Covered

**Group Name:**

**Specialty Business (group size 2-50)**

**Anthem Life** – Attach a copy of the current schedule of benefits or other complete description of the benefits desired.

Class	Class Description	Basic Term Life/AD&D	Dependent Life Spouse/Child	STD Benefit % and Maximum	LTD Benefit % and Maximum
Example	Managers	1 x salary to \$50,000	\$5,000/\$2,500	60% to \$750	60% to \$6,000

(Census must include salaries to quote salary-based life, STD or LTD and must include occupations for LTD.)

<b>Combined Bill Life/AD&amp;D</b> (groups 2-50) Flat benefit: \$ _____ Employer contribution: _____%	<b>Short Term Disability</b> (groups 2-50) Employer contribution: _____% <b>Duration (accident/sickness/weeks)</b> <input type="checkbox"/> 1/8/13 <input type="checkbox"/> 1/8/26 <input type="checkbox"/> 1/8/52 <input type="checkbox"/> 8/8/13 <input type="checkbox"/> 8/8/26 <input type="checkbox"/> 8/8/52 <input type="checkbox"/> 15/15/13 <input type="checkbox"/> 15/15/26 <input type="checkbox"/> 15/15/52 <input type="checkbox"/> 30/30/13 <input type="checkbox"/> 30/30/26 <input type="checkbox"/> 30/30/52 <input type="checkbox"/> Other: _____ <i>Benefits are rounded up to the next \$10.</i>	<b>Long Term Disability</b> (groups 2-19) <input type="checkbox"/> Gold (90- or 180-day elimination period; duration to age 65 with RBD) <input type="checkbox"/> Silver (90- or 180-day elimination period; 5-year/RBD duration) <input type="checkbox"/> Bronze (180-day elimination period; 2-year/RBD duration)
<b>Life/AD&amp;D</b> (groups 2-50) Employer contribution: _____% <input type="checkbox"/> Flat benefit <input type="checkbox"/> Salary-based benefit <b>Reduction Schedule:</b> <input type="checkbox"/> 35% at 65, 60% at 70, 72% at 75, 80% at 80 <input type="checkbox"/> 35% at 65, 50% at 70 <input type="checkbox"/> Other _____	<b>Long Term Disability</b> (groups 20-50) Employer contribution: _____% Elimination period: <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days <input type="checkbox"/> Other _____ Definition of Disability: <input type="checkbox"/> 2 year <input type="checkbox"/> 3 year <input type="checkbox"/> 5 year <input type="checkbox"/> Extended with residual <input type="checkbox"/> Other _____ Maximum payment period: <input type="checkbox"/> 2years w/RBD <input type="checkbox"/> 5 years w/RBD <input type="checkbox"/> Age 65 w/RBD <input type="checkbox"/> Other _____ Pre-existing condition: <input type="checkbox"/> 12/6/24 <input type="checkbox"/> 3/6/12 <input type="checkbox"/> 12/24 <input type="checkbox"/> 3/12 exclusion <input type="checkbox"/> Other _____ <i>Occupations, salaries, DOB, gender required.</i>	
<b>Voluntary Life</b> (groups with 10-50 participating employees) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Quoted with rate sheet.</i>	<b>Voluntary STD Plan</b> (groups with 10-50 participating employees) <input type="checkbox"/> Salary-based benefit: <input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 66 2/3% <input type="checkbox"/> 70% <input type="checkbox"/> Other _____ <input type="checkbox"/> Flat benefit per week \$ _____ <b>Maximum benefit amount:</b> \$750 per week for groups with 10-50 lives (Occupational classes A, B, C, D) Accident: <input type="checkbox"/> 1 day <input type="checkbox"/> 8 days <input type="checkbox"/> 15 days <input type="checkbox"/> 30 days <input type="checkbox"/> Other _____ Sickness: <input type="checkbox"/> 8 days <input type="checkbox"/> 15 days <input type="checkbox"/> 30 days <input type="checkbox"/> Other _____ Duration: <input type="checkbox"/> 13 weeks <input type="checkbox"/> 26 weeks <input type="checkbox"/> 52 weeks <input type="checkbox"/> Other _____ Pre-existing conditions: <input type="checkbox"/> 3/12 <input type="checkbox"/> 3/6/12	<b>Supplemental Life</b> (groups 20-50) <input type="checkbox"/> Salary-based benefit maximum _____ <input type="checkbox"/> Increments of \$10,000 benefit max _____ <input type="checkbox"/> Flat benefit \$ _____
		<b>Supplemental AD&amp;D</b> (groups 20-50) <input type="checkbox"/> Yes <input type="checkbox"/> No

**Anthem Blue Vision<sup>SM</sup>**

Option	Copays Exam/Materials	Frequency Limits (months) Exam/Lens/Frames	Non-network Benefit Schedule
1 <input type="checkbox"/> Exam Plus	\$5/discount	12 months – exam only	Covered – exam only
3 <input type="checkbox"/> Full Service	\$10/\$20	12/24/24	Covered
4 <input type="checkbox"/> Full Service	\$10/\$20	12/12/24	Covered
5 <input type="checkbox"/> Full Service	\$5/\$10	12/12/24	Covered
7 <input type="checkbox"/> Full Service	\$5/\$10	12/12/12	Covered

Dollar limits may apply to frames and contact lenses.

Missing options only available to large group.

**Anthem Blue Vision Non-network Benefit Schedule**

Procedure/Services	Benefit Schedule
Exam	up to \$35
Single vision lenses	up to \$25
Bifocal lenses	up to \$40
Progressive lenses	up to \$40
Trifocal lenses	up to \$55
Lenticular lenses	up to \$80
Elective contacts	up to \$105 (The limit on contacts is the same for Network and Non-network and includes contact lens professional fees.)
Non-elective contact lenses*	up to \$210
Frame	up to \$45

\*Contact lenses are eligible following cataract surgery or for extreme visual acuity or other functional problems that cannot be corrected by spectacle lenses.

**Group Name:**

**Specialty Business (group size 2-50)**

**Anthem Dental\***

**\*\*When choosing PPO Flex, check the appropriate option number in the PPO Flex column. PPO Flex means that both Network and Non-network cost shares are paid by the member at the Network level.**

PPO	PPO Flex**	Deductible Single/Family Network and Non-network combined	Annual Maximums Network and Non-network combined	CLASS I	CLASS II		CLASS III	CLASS IV	Check if Yes		
				Preventive	Basic		Major	Orthodontic Network/Non-network/ Lifetime Maximum	Stand-alone Dental	First-year Dental	
				Diagnostic and Preventive Network/ Non-network	General and Restorative Network/ Non-network	Specialty Services Endodontic, Oral Surgery, and Periodontal Network/Non-network	Prosthodontic Network/Non-network				
Option 1 <input type="checkbox"/>	Option 10 <input type="checkbox"/>	\$50/\$150	\$1,000	CIF/20%	20%/40%					<input type="checkbox"/>	<input type="checkbox"/>
Option 2 <input type="checkbox"/>	Option 11 <input type="checkbox"/>	\$50/\$150	\$750	20%/40%	50%/50%	50%/50%	50%/50%			<input type="checkbox"/>	<input type="checkbox"/>
Option 3 <input type="checkbox"/>	Option 12 <input type="checkbox"/>	\$75/\$225	\$1,000	20%/40%	50%/50%	50%/50%	50%/50%			<input type="checkbox"/>	<input type="checkbox"/>
Option 4 <input type="checkbox"/>	Option 13 <input type="checkbox"/>	\$50/\$150	\$1,000	20%/40%	50%/50%	50%/50%	50%/50%			<input type="checkbox"/>	<input type="checkbox"/>
Option 5 <input type="checkbox"/>	Option 14 <input type="checkbox"/>	\$75/\$225	\$1,000	20%/40%	50%/50%	50%/50%	50%/50%	50%/50%/\$750		<input type="checkbox"/>	<input type="checkbox"/>
Option 6 <input type="checkbox"/>	Option 15 <input type="checkbox"/>	\$50/\$150	\$1,000	CIF/20%	20%/40%	20%/40%	50%/50%			<input type="checkbox"/>	<input type="checkbox"/>
Option 7 <input type="checkbox"/>	Option 16 <input type="checkbox"/>	\$50/\$150	\$1,000	CIF/20%	20%/40%	20%/40%	50%/50%	50%/50%/\$1,000		<input type="checkbox"/>	<input type="checkbox"/>
Option 8 <input type="checkbox"/>	Option 17 <input type="checkbox"/>	\$50/\$150	\$1,500	CIF/20%	20%/40%	20%/40%	50%/50%			<input type="checkbox"/>	<input type="checkbox"/>
Option 9 <input type="checkbox"/>	Option 18 <input type="checkbox"/>	\$50/\$150	\$1,500	CIF/20%	20%/40%	20%/40%	50%/50%	50%/50%/\$1,000		<input type="checkbox"/>	<input type="checkbox"/>
Option 19 <input type="checkbox"/>	Option 35 <input type="checkbox"/>	\$50/\$150	\$1,000	CIF/20%	50%/50%	50%/50%				<input type="checkbox"/>	<input type="checkbox"/>
Option 20 <input type="checkbox"/>	Option 36 <input type="checkbox"/>	\$75/\$225	\$1,000	CIF/20%	20%/40%	20%/40%				<input type="checkbox"/>	<input type="checkbox"/>
Option 21 <input type="checkbox"/>	Option 38 <input type="checkbox"/>	\$50/\$150	\$1,000	CIF/20%	20%/40%	20%/40%				<input type="checkbox"/>	<input type="checkbox"/>
Option 22 <input type="checkbox"/>	Option 37 <input type="checkbox"/>	\$50/\$150	\$1,000	20%/40%	50%/50%	50%/50%	50%/50%	50%/50%/\$1,000		<input type="checkbox"/>	<input type="checkbox"/>
Option 23 <input type="checkbox"/>	Option 39 <input type="checkbox"/>	\$25/\$75	\$1,000	CIF/20%	20%/40%	20%/40%				<input type="checkbox"/>	<input type="checkbox"/>
Option 24 <input type="checkbox"/>	Option 40 <input type="checkbox"/>	\$75/\$225	\$1,000	20%/40%	20%/40%	50%/50%	50%/50%			<input type="checkbox"/>	<input type="checkbox"/>
Option 25 <input type="checkbox"/>	Option 41 <input type="checkbox"/>	\$25/\$75	\$1,000	20%/40%	50%/50%	50%/50%	50%/50%	50%/50%/\$1,000		<input type="checkbox"/>	<input type="checkbox"/>
Option 26 <input type="checkbox"/>	Option 42 <input type="checkbox"/>	\$50/\$150	\$1,000	20%/40%	20%/40%	50%/50%	50%/50%	50%/50%/\$1,000		<input type="checkbox"/>	<input type="checkbox"/>
Option 27 <input type="checkbox"/>	Option 43 <input type="checkbox"/>	\$25/\$75	\$1,000	20%/40%	20%/40%	50%/50%	50%/50%	50%/50%/\$1,000		<input type="checkbox"/>	<input type="checkbox"/>
Option 28 <input type="checkbox"/>	Option 44 <input type="checkbox"/>	\$50/\$150	\$1,000	CIF/20%	20%/40%	50%/50%	50%/50%			<input type="checkbox"/>	<input type="checkbox"/>
Option 29 <input type="checkbox"/>	Option 45 <input type="checkbox"/>	\$25/\$75	\$1,000	CIF/20%	20%/40%	50%/50%	50%/50%	50%/50%/\$1,000		<input type="checkbox"/>	<input type="checkbox"/>
Option 30 <input type="checkbox"/>	Option 46 <input type="checkbox"/>	\$25/\$75	\$1,000	CIF/20%	20%/40%	40%/50%	40%/50%	50%/50%/\$1,000		<input type="checkbox"/>	<input type="checkbox"/>
Option 31 <input type="checkbox"/>	Option 47 <input type="checkbox"/>	None	\$1,000	CIF/20%	20%/40%	40%/50%	40%/50%	50%/50%/\$1,000		<input type="checkbox"/>	<input type="checkbox"/>
Option 32 <input type="checkbox"/>	Option 48 <input type="checkbox"/>	\$50/\$150	\$1,000	CIF/CIF	10%/20%	10%/20%	50%/50%			<input type="checkbox"/>	<input type="checkbox"/>
Option 33 <input type="checkbox"/>	Option 49 <input type="checkbox"/>	None	\$1,000	CIF/20%	20%/40%	20%/40%	50%/50%			<input type="checkbox"/>	<input type="checkbox"/>
Option 34 <input type="checkbox"/>	Option 50 <input type="checkbox"/>	\$50/\$150	\$1,000	CIF/CIF	CIF/20%	CIF/20%	40%/50%	50%/50%/\$1,000		<input type="checkbox"/>	<input type="checkbox"/>
Option 51 <input type="checkbox"/>	Option 52 <input type="checkbox"/>	\$50/\$150	\$2,000	CIF/20%	20%/40%	20%/40%	50%/50%	50%/50%/\$2,000		<input type="checkbox"/>	<input type="checkbox"/>

**Note:** CIF means covered in full up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment, including but not limited to, benefits that are covered in full.

**\*Anthem Dental Notes:**

- Orthodontic child (to age 19) only. For groups without prior orthodontic coverage, a 12-month waiting period applies.
- For groups without prior prosthodontic coverage, a 12-month waiting period applies.
- Deductibles do not apply to diagnostic, preventive or orthodontics.
- Orthodontic lifetime maximum does not apply to the annual maximum.
- Percentages reflect member's responsibility.

**Group Name:**

**Specialty Business (group size 2-50)**

**Anthem Dental**

**\*Summary of Benefits**

**Diagnostic and Preventive Services (no deductible)**

Covered services include oral evaluations, X-rays, cleanings, space maintainers and other selected diagnostic and preventive services.

**General (Adjunctive) Services (deductible applied)**

Covered services include emergency palliative treatment, consultations, general anesthesia and I.V. sedation for surgical procedures, office visits for observation, and other selected general services.

**Restorative Services (deductible applied)**

Covered services include amalgam and composite restorations and pin retention procedures.

**Endodontic Services (deductible applied)**

Covered services include root canal therapy, apexification, therapeutic pulpotomy and other selected endodontic services.

**Oral Surgery Services (deductible applied)**

Covered services include simple and surgical tooth extractions and other selected oral surgery services.

**Periodontal Services (deductible applied)**

Covered services include gingivectomy, crown lengthening, osseous surgery, soft tissue grafts and other selected periodontal services.

**Prosthodontic Services (deductible applied)**

Covered services include crowns/onlays, partial and full dentures and other selected prosthodontic services.

**Orthodontic Services (no deductible)**

**Available as an optional benefit applies to 15+ enrolled (10+ enrolled if prior orthodontic coverage).**

Benefit includes non-surgical dental services related to the supervision, guidance and correction of growing or mature teeth; covered services include examination, records, tooth guidance and repositioning (straightening) of the teeth.

**Anthem Dental Traditional**

	Deductible Single/Family	Annual Maximums	Class I	Class II		Class III	Class IV	Check if Yes	
			Preventive	Basic A	Basic B	Major	Orthodontic	Stand-alone Dental	First-year Dental
				General	Specialty Services				
Option 1 <input type="checkbox"/>	\$50/\$100	\$750	CIF	50%	50%	50%		<input type="checkbox"/>	<input type="checkbox"/>
Option 2 <input type="checkbox"/>	\$50/\$100	\$1,000	CIF	20%	20%	50%		<input type="checkbox"/>	<input type="checkbox"/>
Option 3 <input type="checkbox"/>	\$50/\$100	\$1,000	CIF	20%	20%	50%	40%/\$1,000	<input type="checkbox"/>	<input type="checkbox"/>
Option 4 <input type="checkbox"/>	\$25/\$50	\$1,000	CIF	20%	20%	50%		<input type="checkbox"/>	<input type="checkbox"/>
Option 5 <input type="checkbox"/>	\$25/\$50	\$1,000	CIF	20%	20%	50%	40%/\$1,000	<input type="checkbox"/>	<input type="checkbox"/>

Note: CIF means covered in full up to the maximum allowable amount. However, a member may be responsible for any balance due after the plan payment, including but not limited to, benefits that are covered in full.

**Anthem Dental Traditional Notes**

- Deductibles do not apply to preventive or orthodontics.
- Orthodontic child (to age 19) only. For groups without prior orthodontic coverage, a 12-month waiting period applies.
- For groups without prior prosthodontic coverage, a 12-month waiting period applies.
- Orthodontic lifetime maximum does not apply to the annual maximum.

**Anthem Dental Traditional**

**Summary of Benefits**

**Class I Preventive Services (no deductible)**

Covered services include exams, oral evaluations, X-rays (bitewing and complete series), cleaning and scaling, space maintainers and other selected diagnostic and preventive services.

**Class II General Services (deductible applies)**

Covered services include palliative (emergency) treatment, consultations, general anesthesia, intravenous sedation, office visits for observation, amalgam and composite restorations and pin retention procedures.

**Class II Specialty Services (deductible applies)**

Covered services include root canal therapy, apexification/recalcification, therapeutic pulpotomy, oral surgery, simple and surgical tooth extractions, periodontic services, gingivectomy, osseous surgery and other selected endodontics, oral surgery and periodontal services.

**Class III Prosthodontic Services (deductible applies)**

Covered services include onlays, crowns, dentures, bridges and repair of dentures and bridgework, implants and other selected periodontal services.

**Class IV Orthodontia Services (no deductible)**

**Applies to 15+ enrolled (10+ enrolled if prior orthodontic coverage).** Covered services include examination, records, minor treatment of tooth guidance, repositioning (straightening) of the teeth, interceptive or comprehensive orthodontic treatment and post-treatment stabilization.