

# Your Anthem Benefits



## Shaker Heights City Schools Anthem Dental Blue 100/200/300 (group size 51+) Summary of Benefits, Effective 01/01/2020

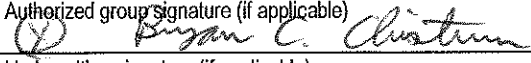
This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, exclusions, qualifications, limitations, terms and provisions of the Dental Certificate.

| BENEFITS   | NETWORK/NON-NETWORK (MEMBER'S RESPONSIBILITY) |
|--|---|
| Annual Deductible (per each family member)   | \$50 per member                               |
| Annual Maximum   | \$1500 Network and non-Network combined       |
| <b>DIAGNOSTIC/PREVENTIVE</b>   | Covered in full Network and non-Network       |
| Diagnostic and Preventive Services (no deductible) <ul style="list-style-type: none"> <li>oral evaluations</li> <li>X-rays</li> <li>cleanings</li> <li>space maintainers</li> <li>other selected diagnostic and preventive services</li> <li>X-ray (full mouth)</li> </ul>   |   |
| <b>PRIMARY</b>   | 15% Network/15% Non-network                   |
| General (Adjunctive) Services (no deductible) <ul style="list-style-type: none"> <li>I.V. sedation (surgical procedures)</li> <li>Amalgam and composite restorations</li> <li>Pin retention procedures</li> <li>Root canal therapy</li> <li>Apexification</li> <li>Therapeutic pulpotomy</li> <li>Other selected endodontic services</li> <li>Simple and surgical tooth extractions</li> <li>Other selected oral surgery services</li> <li>Gingivectomy</li> <li>Osseous Surgery</li> <li>Other selected periodontal services</li> <li>Palliative treatment</li> </ul> |   |
| <b>COMPLEX</b>   | 20% Network/20% Non-network                   |
| <ul style="list-style-type: none"> <li>Crowns/inlays/onlays (deductible applied)</li> <li>Partial and full dentures</li> <li>Other selected prosthodontics services</li> </ul> <b>Missing Tooth Benefit</b><br>Services for the replacement of teeth (tooth) lost prior to the member's effective date of coverage under this plan. <ul style="list-style-type: none"> <li>Removable prosthodontics (partials or dentures)</li> <li>fixed prosthodontics (bridges) for the replacement of teeth (or tooth)</li> </ul>  | Covered                                       |
| <b>ORTHODONTIC</b>   | 50% Network/50% Non-network                   |
| Orthodontic Services (deductible applied) <ul style="list-style-type: none"> <li>Non-surgical dental services related to the supervision, guidance and correction of growing or mature teeth</li> <li>Examination</li> <li>Records</li> <li>Tooth Guidance</li> <li>Repositioning (straightening) of the teeth</li> <li>Post orthodontic retention</li> </ul>  |   |
| <b>BENEFITS</b>  | <b>NETWORK/NON-NETWORK</b>                    |
| Separate Orthodontic Lifetime Maximum  | \$1500  |

Dependent age: to the end of the month in which the child attains age 26.

\* 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.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

|   |                  |
|---|------------------|
| Authorized group signature (if applicable)<br> | Date<br>10/28/19 |
| Underwriting signature (if applicable)  | Date             |