Your Anthem Benefits

Anthem

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
DIAGNOSTIC/PREVENTIVE	Covered in full Network and non-Network
Diagnostic and Preventive Services (no deductible) • oral evaluations • X-rays • cleanings • space maintainers • other selected diagnostic and preventive services • X-ray (full mouth)	
PRIMARY	15% Network/15% Non-network
General (Adjunctive) Services *(no deductible)* • I.V. sedation (surgical procedures) • Amalgam and composite restorations • Pin retention procedures • Root canal therapy • Apexification • Therapeutic pulpotomy • Other selected endodontic services • Simple and surgical tooth extractions • Other selected oral surgery services • Gingivectomy • Osseous Surgery • Other selected periodontal services • Palliative treatment	
COMPLEX	20% Network/20% Non-network
• Crowns/inlays/onlays (deductible applied) • Partial and full dentures • Other selected prosthodontics services	
Missing Tooth Benefit *Services for the replacement of teeth (tooth) lost prior to the member's effective date of coverage under this plan.* • Removable prosthodontics (partials or dentures) fixed prosthodontics (bridges) for the replacement of teeth (or tooth)	Covered
ORTHODONTIC	50% Network/50% Non-network
Orthodontic Services *(deductible applied)* • Non-surgical dental services related to the supervision, guidance and correction of growing or mature teeth • Examination • Records • Tooth Guidance • Repositioning (straightening) of the teeth • Post orthodontic retention	

BENEFITS	NETWORK/NON-NETWORK
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) Susan C. Christman	Date 10/28/19
Underwriting signature (if applicable)	Date