

Group Quote Request Form (group sizes 2-50 and 51+)



Anthem fax number		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		Rates: <input type="checkbox"/> Composite <input type="checkbox"/> Age/Sex		
Broker fax number		Broker phone number/email			Group name/group number			Group contact name/phone no.		
Group address				City, State, ZIP code			Type of industry		SIC code	

Lumenos[®] Health Savings Accounts Cost Share Options 1-12 – Network: Blue AccessSM Plan Options are Integrated with the Mellon HSA solution

Employer Funded/ASO HSA Incentives: When selecting one of the following HSA plan designs, if the Group does not offer a Section 125/Cafeteria Plan, the employer should consult with a tax advisor to avoid tax penalties.

Calendar Year	Optional Rewards Included (Yes/No)	Network							Network & Non-network Emergency Room Services @ Hospital	Non-Network		Prescription Drug		Lumenos [®] Product Code
		Physician Home and Office Services	Network and Non-network Combined Deductible Single/Family	Inpatient Facility	Outpatient Surgery: Hospital/Alternative Care Facility	Other Outpatient Services*	Inpatient/Outpatient Professional Services	Out-of-Pocket Maximum Single/Family		Covered Services Coinsurance unless otherwise stated	Out-of-Pocket Maximum Single/Family	Network	Non-Network	
Option 001	<input type="checkbox"/> Yes	10%	\$1,250/\$2,500	10%	10%	10%	10%	\$2,500/\$5,000	10%	30%	\$5,000/\$10,000	10%	30%	GHSA1
Option 002	<input type="checkbox"/> Yes	20%	\$1,250/\$2,500	20%	20%	20%	20%	\$5,000/\$10,000	20%	40%	\$10,000/\$20,000	20%	40%	GHSA2
Option 003	<input type="checkbox"/> Yes	0%	\$1,500/\$3,000	0%	0%	0%	0%	\$1,500/\$3,000	0%	30%	\$3,000/\$6,000	0%	30%	GHSA3
Option 004	<input type="checkbox"/> Yes	10%	\$1,500/\$3,000	10%	10%	10%	10%	\$3,000/\$6,000	10%	30%	\$6,000/\$12,000	10%	30%	GHSA4
Option 005	<input type="checkbox"/> Yes	20%	\$1,500/\$3,000	20%	20%	20%	20%	\$5,000/\$10,000	20%	40%	\$10,000/\$20,000	20%	40%	GHSA5
Option 006	<input type="checkbox"/> Yes	0%	\$2,000/\$4,000	0%	0%	0%	0%	\$2,000/\$4,000	0%	30%	\$4,000/\$8,000	0%	30%	GHSA6
Option 007	<input type="checkbox"/> Yes	20%	\$2,000/\$4,000	20%	20%	20%	20%	\$5,000/\$10,000	20%	40%	\$10,000/\$20,000	20%	40%	GHSA7
Option 008	<input type="checkbox"/> Yes	0%	\$2,500/\$5,000	0%	0%	0%	0%	\$2,500/\$5,000	0%	30%	\$5,000/\$10,000	0%	30%	GHSA8
Option 009	<input type="checkbox"/> Yes	20%	\$2,500/\$5,000	20%	20%	20%	20%	\$5,000/\$10,000	20%	40%	\$10,000/\$20,000	20%	40%	GHSA9
Option 010	<input type="checkbox"/> Yes	0%	\$3,000/\$6,000	0%	0%	0%	0%	\$3,000/\$6,000	0%	30%	\$6,000/\$12,000	0%	30%	GHSA10
Option 011	<input type="checkbox"/> Yes	20%	\$3,000/\$6,000	20%	20%	20%	20%	\$5,000/\$10,000	20%	40%	\$10,000/\$20,000	20%	40%	GHSA11
Option 012	<input type="checkbox"/> Yes	0%	\$5,000/\$10,000	0%	0%	0%	0%	\$5,000/\$10,000	0%	30%	\$10,000/\$20,000	0%	30%	GHSA12
Option E08	<input type="checkbox"/> Yes	0%	\$2,500/\$5,000	0%	0%	0%	0%	\$2,500/\$5,000	0%	30%	\$5,000/\$10,000	0%	30%	GEHSA8
Option E09	<input type="checkbox"/> Yes	20%	\$2,500/\$5,000	20%	20%	20%	20%	\$5,000/\$10,000	20%	40%	\$10,000/\$20,000	20%	40%	GEHSA9
Option E10	<input type="checkbox"/> Yes	0%	\$3,000/\$6,000	0%	0%	0%	0%	\$3,000/\$6,000	0%	30%	\$6,000/\$12,000	0%	30%	GEHSA10
Option E11	<input type="checkbox"/> Yes	20%	\$3,000/\$6,000	20%	20%	20%	20%	\$5,000/\$10,000	20%	40%	\$10,000/\$20,000	20%	40%	GEHSA11
Option E12	<input type="checkbox"/> Yes	0%	\$5,000/\$10,000	0%	0%	0%	0%	\$5,000/\$10,000	0%	30%	\$10,000/\$20,000	0%	30%	GEHSA12

Group Name:

Lumenos[®] Health Savings Accounts Cost Share Options – Network: Blue AccessSM

Plan Year	Optional Rewards Included (Yes/No)	Network							Network & Non-network Emergency Room Services @ Hospital	Non-Network		Prescription Drug		Lumenos [®] Product Code
		Physician Home and Office Services	Network and Non-network Combined Deductible Single/Family	Inpatient Facility	Outpatient Surgery: Hospital/Alternative Care Facility	Other Outpatient Services*	Inpatient/Outpatient Professional Services	Out-of-Pocket Maximum Single/Family		Covered Services Coinsurance unless otherwise stated	Out-of-Pocket Maximum Single/Family	Network	Non-Network	
Option P01 <input type="checkbox"/>	Yes	10%	\$1,250/\$2,500	10%	10%	10%	10%	\$2,500/\$5,000	10%	30%	\$5,000/\$10,000	10%	30%	GHSA1
Option P02 <input type="checkbox"/>	Yes	20%	\$1,250/\$2,500	20%	20%	20%	20%	\$5,000/\$10,000	20%	40%	\$10,000/\$20,000	20%	40%	GHSA2
Option P03 <input type="checkbox"/>	Yes	0%	\$1,500/\$3,000	0%	0%	0%	0%	\$1,500/\$3,000	0%	30%	\$3,000/\$6,000	0%	30%	GHSA3
Option P04 <input type="checkbox"/>	Yes	10%	\$1,500/\$3,000	10%	10%	10%	10%	\$3,000/\$6,000	10%	30%	\$6,000/\$12,000	10%	30%	GHSA4
Option P05 <input type="checkbox"/>	Yes	20%	\$1,500/\$3,000	20%	20%	20%	20%	\$5,000/\$10,000	20%	40%	\$10,000/\$20,000	20%	40%	GHSA5
Option P06 <input type="checkbox"/>	Yes	0%	\$2,000/\$4,000	0%	0%	0%	0%	\$2,000/\$4,000	0%	30%	\$4,000/\$8,000	0%	30%	GHSA6
Option P07 <input type="checkbox"/>	Yes	20%	\$2,000/\$4,000	20%	20%	20%	20%	\$5,000/\$10,000	20%	40%	\$10,000/\$20,000	20%	40%	GHSA7
Option P08 <input type="checkbox"/>	Yes	0%	\$2,500/\$5,000	0%	0%	0%	0%	\$2,500/\$5,000	0%	30%	\$5,000/\$10,000	0%	30%	GHSA8
Option P09 <input type="checkbox"/>	Yes	20%	\$2,500/\$5,000	20%	20%	20%	20%	\$5,000/\$10,000	20%	40%	\$10,000/\$20,000	20%	40%	GHSA9
Option P10 <input type="checkbox"/>	Yes	0%	\$3,000/\$6,000	0%	0%	0%	0%	\$3,000/\$6,000	0%	30%	\$6,000/\$12,000	0%	30%	GHSA10
Option P11 <input type="checkbox"/>	Yes	20%	\$3,000/\$6,000	20%	20%	20%	20%	\$5,000/\$10,000	20%	40%	\$10,000/\$20,000	20%	40%	GHSA11
Option P12 <input type="checkbox"/>	Yes	0%	\$5,000/\$10,000	0%	0%	0%	0%	\$5,000/\$10,000	0%	30%	\$10,000/\$20,000	0%	30%	GHSA12
Option A08 <input type="checkbox"/>	Yes	0%	\$2,500/\$5,000	0%	0%	0%	0%	\$2,500/\$5,000	0%	30%	\$5,000/\$10,000	0%	30%	GEHSA8
Option A09 <input type="checkbox"/>	Yes	20%	\$2,500/\$5,000	20%	20%	20%	20%	\$5,000/\$10,000	20%	40%	\$10,000/\$20,000	20%	40%	GEHSA9
Option A10 <input type="checkbox"/>	Yes	0%	\$3,000/\$6,000	0%	0%	0%	0%	\$3,000/\$6,000	0%	30%	\$6,000/\$12,000	0%	30%	GEHSA10
Option A11 <input type="checkbox"/>	Yes	20%	\$3,000/\$6,000	20%	20%	20%	20%	\$5,000/\$10,000	20%	40%	\$10,000/\$20,000	20%	40%	GEHSA11
Option A12 <input type="checkbox"/>	Yes	0%	\$5,000/\$10,000	0%	0%	0%	0%	\$5,000/\$10,000	0%	30%	\$10,000/\$20,000	0%	30%	GEHSA12

Coinsurance applies **after** the deductible. 0% means no coinsurance up to the maximum allowable amount. Refer to the benefit summary for detailed information. For all Options, no deductible and 0% coinsurance up to the maximum allowable amount for Preventive Care Services (Network only). Non-network Preventive Care Services subject to Non-network cost shares.

P = Plan year benefits.

E = Calendar year benefits with an embedded deductible

A = Plan year benefits with an embedded deductible

NOTE: Employer Funded Incentive contributions to employees' Health Savings Accounts must be made through a section 125 cafeteria plan to comply with IRS comparable contribution requirements.

For Small Groups only (2 – 50): A plan selection within a group of an HRA and an HSA with identical health plan benefits is available in all situations. Also, should you select a Lumenos HSA or HRA plan in addition to a Core Option, please work with your Anthem Sales Representative to maintain at least a 10% and no more than a 50% spread between the Core and the Buy-up option. In all other situations involving a Core Option and a Buy-up Option, please work with your Anthem Sales Representative to maintain at least a 10% and no more than a 35% pricing spread between the Core and the Buy-up option.

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:

Lumenos[®] Health Savings Accounts Cost Share Options – Network: Blue AccessSM

Optional Rewards:

Completion of Online MyHealth Assessment	Participation in a Health Coaching Program	Graduation from a Health Coaching Program	Participation and completion of Tobacco-Free Program	Participation and completion of Healthy Weight Program
\$50 Gift Card	\$100 Gift Card	\$200 Gift Card	\$50 Gift Card	\$50 Gift Card

ASO Groups will have employer Funded Incentives. Fully Insured Group will have incentives paid in the form of a gift card. The amount of the gift card is considered taxable income to the employee. A tax advisor may be consulted for guidance on tax issues.

Notes:

- Deductible(s) apply only to covered services listed with a percentage (%) coinsurance (including prescription drugs).
- Once the family deductible is satisfied by either one member or all members collectively, then the additional percentage coinsurance will be required for the family until the family out-of-pocket is satisfied. Does not apply to embedded deductible options.

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

All Health Options include the following:

Ambulance/Hospice/Urgent Care Facility:
Paid at the **Network** level.

Skilled Nursing Facility (Network and Non-network combined):
Limited to 100 days per benefit period

Home Care Services (Network and Non-network combined):
Limited to 100 visits (excludes Private Duty Nursing)
Private Duty Nursing – limited to \$50,000 annually with a lifetime maximum of \$100,000

Physical Medicine and Rehabilitation (Network and Non-network combined):
Limited to 60 days per benefit period, includes Day Rehabilitation programs.

Behavioral Health Services:

Non-biologically based Mental Illnesses and Substance Abuse (Network):

Inpatient: Limited to 30 days per benefit period (includes Non-network)
Outpatient: Limited to 30 visits per benefit period
Biologically based Mental Illnesses are paid the same as any other illness.

Outpatient Therapy (Network and Non-network combined):

Physical Therapy: 20 visits
Occupational Therapy: 20 visits
Manipulation Therapy: 12 visits
Speech Therapy: 20 visits

Durable Medical Equipment and Orthotics (Network and Non-network combined):
Subject to benefit maximum of \$4,000 per benefit period (excluding Prosthetic Devices and Medical Supplies).
Prosthetic Devices \$4,000 limit applies per benefit period.

Wigs:
\$500 maximum per benefit period for wigs due to cancer diagnosis.

Lumenos[®] Health Savings Accounts

Notes:

- **Network and non-Network deductible is combined.**
- All deductibles and coinsurance apply toward the out-of-pocket maximum including prescription drugs. (Excludes **Non-network** human organ and tissue transplants)
- **Network and Non-network** coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- \$5 million medical lifetime maximum for all covered medical services. However, once the medical lifetime maximum is met, no additional prescription drug claims will be paid.
- Benefit period = calendar year or plan year
- **Non-biologically based Mental Illness and Substance Abuse (Non-network):**
 - Inpatient mental health combined with Network day limits.
 - Outpatient mental health is limited to 10 visits per benefit period.
 - Combined inpatient and outpatient substance abuse is limited to \$550 per benefit period.
 - Inpatient and outpatient substance abuse rehabilitation programs are limited to two per lifetime (**Network and Non-network combined**).
- Biologically based Mental Illnesses are paid the same as any other illness.
- Prescription Drug:
 - 30-day supply for **Network and Non-network** pharmacy (does not include drugs obtained through mail service pharmacy).
 - Certain diabetic and asthmatic supplies are not covered at **Non-network** pharmacies (except Diabetic test strips).
- Anthem Rx Mail Service:
 - 90-day supply
 - **Non-network** not covered.

Group Name:

Lumenos[®] Health Savings Accounts Cost Share Options – Network: Blue AccessSM

100+ group size only:

Dependent Eligibility			
End of Calendar Year	End of Month	To Birthday	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Age 19 only
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Age 19; 21, full-time student
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Age 19; 23, full-time student
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Age 19; 24, full-time student
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Age 19; 25, full-time student
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Age 18; 23, federal tax exemption

Note: Bolded text is the standard Dependent Eligibility.

Medicare Rx Options
<input type="checkbox"/> Wrap
<input type="checkbox"/> Subsidy*
<input type="checkbox"/> Waiver

**Subsidy is only available to 100+ size groups.*

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.)

Combined Bill Life/AD&D (groups 2-50)	Short Term Disability (groups 2-50)	Long Term Disability (groups 2-19)
Flat benefit: \$ _____ Employer contribution: _____%	Employer contribution: _____% Duration (accident/sickness/weeks) <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>	<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)
Life/AD&D (groups 2-50) Employer contribution: _____% <input type="checkbox"/> Flat benefit <input type="checkbox"/> Salary-based benefit Reduction Schedule: <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 _____		Long Term Disability (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>
Voluntary Life (groups with 10-50 participating employees) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Quoted with rate sheet.</i>	Voluntary STD Plan (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 \$ _____ Maximum benefit amount: \$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	Supplemental Life (groups 20-50) <input type="checkbox"/> Salary-based benefit maximum _____ <input type="checkbox"/> Increments of \$10,000 benefit max _____ <input type="checkbox"/> Flat benefit \$ _____ Supplemental AD&D (groups 20-50) <input type="checkbox"/> Yes <input type="checkbox"/> No

Anthem Blue VisionSM

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/Progressive lenses	up to \$40
Trifocal lenses	up to \$55
Lenticular lenses	up to \$80
Elective contacts	up to \$105 (The reimbursement amount 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 PPO*

****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
				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"/>
Option 2 <input type="checkbox"/>	Option 11 <input type="checkbox"/>	\$50/\$150	\$750	20%/40%	50%/50%	50%/50%	50%/50%		<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"/>
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"/>
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"/>
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"/>
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"/>
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"/>
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"/>
Option 19 <input type="checkbox"/>	Option 35 <input type="checkbox"/>	\$50/\$150	\$1,000	CIF/20%	50%/50%	50%/50%			<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"/>
Option 21 <input type="checkbox"/>	Option 38 <input type="checkbox"/>	\$50/\$150	\$1,000	CIF/20%	20%/40%	20%/40%			<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"/>
Option 23 <input type="checkbox"/>	Option 39 <input type="checkbox"/>	\$25/\$75	\$1,000	CIF/20%	20%/40%	20%/40%			<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"/>
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"/>
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"/>
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"/>
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"/>
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"/>
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"/>
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"/>
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"/>
Option 33 <input type="checkbox"/>	Option 49 <input type="checkbox"/>	None	\$1,000	CIF/20%	20%/40%	20%/40%	50%/50%		<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"/>
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"/>

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 PPO 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 PPO

*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 Preventive	Class II		Class III Major Prosthodontic	Class IV Orthodontic Copoly/ Lifetime Maximum	Check if Yes Stand-alone Dental
				Basic A General	Basic B Specialty Services			
				Option 1 <input type="checkbox"/>	\$50/\$100			
Option 2 <input type="checkbox"/>	\$50/\$100	\$1,000	CIF	20%	20%	50%	<input type="checkbox"/>	
Option 3 <input type="checkbox"/>	\$50/\$100	\$1,000	CIF	20%	20%	50%	40%/\$1,000 <input type="checkbox"/>	
Option 4 <input type="checkbox"/>	\$25/\$50	\$1,000	CIF	20%	20%	50%	<input type="checkbox"/>	
Option 5 <input type="checkbox"/>	\$25/\$50	\$1,000	CIF	20%	20%	50%	40%/\$1,000 <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.

Group Name:

Specialty Business (group size 51+)

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.)

Life/AD&D	Short Term Disability	Long Term Disability
Employer contribution: _____% <input type="checkbox"/> Flat benefit <input type="checkbox"/> Salary-based benefit Reduction Schedule: <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 _____ <i>Experience required 500+ FTE.</i>	Employer contribution: _____% Duration (accident/sickness/weeks) <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. Experience required 100+ FTE.</i>	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. Experience required 300+ FTE.</i>
Voluntary Life	Voluntary STD Plan	Supplemental Life
<input type="checkbox"/> Yes <input type="checkbox"/> No	<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 \$ _____ Maximum benefit amount: <input type="checkbox"/> \$750 per week for groups with 10-99 lives (Occupational classes A, B, C, D) <input type="checkbox"/> \$1,000 per week for groups with 100+ lives (Occupational classes A & B) <input type="checkbox"/> \$750 per week for groups with 100+ lives (Occupational classes 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	<input type="checkbox"/> Salary-based benefit maximum _____ <input type="checkbox"/> Increments of \$10,000 benefit max _____ <input type="checkbox"/> Flat benefit \$ _____ <hr/> Supplemental AD&D <input type="checkbox"/> Yes <input type="checkbox"/> No

Anthem Blue VisionSM

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
2 <input type="checkbox"/> Full Service	\$20/\$20	12/24/24	Covered
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
6 <input type="checkbox"/> Full Service	\$0/\$0	12/12/24	Covered
7 <input type="checkbox"/> Full Service	\$5/\$10	12/12/12	Covered
8 <input type="checkbox"/> Full Service	\$0/\$0	12/12/12	Covered

Dollar limits may apply to frames and contact lenses.

Anthem Blue Vision Non-network Benefit Schedule

Procedure/Services	Benefit Schedule
Exam	up to \$35
Single vision lenses	up to \$25
Bifocal lenses/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 51+)

Anthem Dental PPO*

****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	Missing Tooth Benefit
				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"/>	<input type="checkbox"/>
Option 2 <input type="checkbox"/>	Option 11 <input type="checkbox"/>	\$50/\$150	\$1,000	20%/40%	50%/50%	50%/50%	50%/50%		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Option 3 <input type="checkbox"/>	Option 12 <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"/>	<input type="checkbox"/>
Option 4 <input type="checkbox"/>	Option 13 <input type="checkbox"/>	\$50/\$150	\$1,000	CIF/20%	20%/40%	20%/40%	50%/50%		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Option 5 <input type="checkbox"/>	Option 14 <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"/>	<input type="checkbox"/>
Option 6 <input type="checkbox"/>	Option 15 <input type="checkbox"/>	\$25/\$75	\$1,000	CIF/20%	20%/40%	20%/40%	50%/50%	50%/50%/\$1,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Option 7 <input type="checkbox"/>	Option 16 <input type="checkbox"/>	\$50/\$150	\$1,500	CIF/20%	20%/40%	20%/40%	50%/50%		<input type="checkbox"/>	<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%	50%/50%/\$1,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Option 9 <input type="checkbox"/>	Option 18 <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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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 PPO Notes:**

- Deductibles do not apply to diagnostic, preventive or orthodontics.
- Orthodontic lifetime maximum does not apply to the annual maximum.
- Orthodontic child to age 19 only.
- Percentages reflect member's responsibility.

Group Name:

Specialty Business (group size 51+)

Anthem Dental PPO

*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. 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.

Missing Tooth Benefit (deductible applied)

Available as an optional benefit. Covered services include removable prosthodontics (partials or dentures) or fixed prosthodontics (bridges) for the replacement of teeth (or tooth) lost prior to the member's effective date of coverage under this Plan.

Anthem Dental Traditional

	Deductible Single/Family	Annual Maximums	Class I	Class II		Class III	Class IV	Check if Yes			Provider Allowance
			Preventive	Basic A	Basic B	Major	Orthodontic	Stand-alone Dental	First-year Dental	Missing Tooth Benefit	
				General	Specialty Services	Prosthodontic	Copay/ Lifetime Maximum				
Option 1 <input type="checkbox"/>	\$50/\$150	\$1,000	20%	20%	20%	50%		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	70% percentile
Option 2 <input type="checkbox"/>	\$50/\$150	\$1,000	20%	20%	20%	50%	40%/\$1,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	70% percentile
Option 3 <input type="checkbox"/>	\$25/NA	\$1,000	20%	20%	20%	50%		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	70% percentile
Option 4 <input type="checkbox"/>	\$50/\$100	\$750	CIF	50%	50%	50%		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	70% percentile
Option 5 <input type="checkbox"/>	\$25/NA	\$1,000	20%	20%	20%	50%	40%/\$1,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	70% percentile
Option 6 <input type="checkbox"/>	\$50/\$150	\$1,000	CIF	20%	20%	50%		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	70% percentile
Option 7 <input type="checkbox"/>	\$50/\$100	\$1,000	CIF	20%	20%	50%		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	70% percentile
Option 8 <input type="checkbox"/>	\$50/\$150	\$1,000	CIF	20%	20%	50%	40%/\$1,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	70% percentile
Option 9 <input type="checkbox"/>	\$50/\$100	\$1,000	CIF	20%	20%	50%	40%/\$1,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	70% percentile
Option 10 <input type="checkbox"/>	\$25/\$50	\$1,000	CIF	20%	20%	50%		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	70% percentile
Option 11 <input type="checkbox"/>	\$25/\$50	\$1,000	CIF	20%	20%	50%	40%/\$1,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	70% percentile

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 lifetime maximum does not apply to the annual maximum.
- Orthodontic child to age 19 only.
- Percentages reflect member's responsibility.

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 prosthodontic services.

Class IV Orthodontia Services (no deductible)

Covered services include examination, records, minor treatment of tooth guidance, repositioning (straightening) of the teeth, interceptive or comprehensive orthodontic treatment and post-treatment stabilization.

Missing Tooth Benefit (deductible applies)

Available as an optional benefit. Covered services include removable prosthodontics (partials or dentures) or fixed prosthodontics (bridges) for the replacement of teeth (or tooth) lost prior to the member's effective date of coverage under this Plan.