Dental Prime for Individuals and Families

For Virginia

Anthem BlueCross BlueShield

Good health starts with a healthy mouth.

Taking care of your teeth and making regular visits to your dentist can help you stay healthy. How? The germs in an unhealthy mouth can affect the rest of the body. And regular dental checkups can help find early warning signs of health issues. That's one reason why it's so important to take good care of your teeth and gums.

Dental Prime can help you get the care you need.

When you have the right dental benefits, you can have a better handle on your total health. That's why our Dental Prime plan offers:

- Exams, cleanings and X-rays covered 100%
- No waiting period for diagnostic and preventive services, such as cleanings, exams and X-rays
- A benefit for a brush biopsy which, together with a surgical biopsy, helps detect oral cancer
- An extra cleaning each year for those who are pregnant or living with diabetes

Choose the plan that's right for you.

Our plans can help you get routine dental care and help you manage your health care costs. And with three options, you're bound to find the Dental Prime plan that's right for you and your family.

	Plan A	Plan B	Plan C
Deductible (The amount you pay before we pay for any services, including diagnostic and preventive)	None	$50 per person	$50 per person
Annual maximum (The most we will pay in one calendar year)	$500 per person	$1,000 per person	$1,250 per person
Diagnostic and preventive care (Such as cleanings, exams and X-rays)	100% covered	100% covered	100% covered
Extra cleanings	Available to those who are pregnant or living with diabetes.		
Basic treatment (Such as fillings and simple tooth extractions)	Not covered	80% covered for fillings and simple tooth extractions.	80% covered for fillings and simple tooth extractions.
Brush biopsy	Not covered	80% covered	80% covered
Major treatment (Such as root canals, scaling, root planing, crowns, dentures and bridges)	Not covered	50% covered for root canals, scaling, root planing and complex surgical extractions. Crowns, dentures, bridges and orthodontics not covered.	50% covered for root canals, scaling, root planing, complex surgical extractions, crowns, dentures, bridges and implants. Orthodontics not covered.
Waiting periods	Diagnostic and preventive care: No waiting period	Diagnostic and preventive care: No waiting period Basic treatment: 6 months Brush biopsy: 6 months Major treatment: 12 months	Diagnostic and preventive care: No waiting period Basic treatment: 6 months Brush biopsy: 6 months Major treatment: 12 months

Premiums (Annual rates reflect a 5% discount when pre-paying annually)	Plan A		Plan B		Plan C	
	Monthly	**Annual**	**Monthly**	**Annual**	**Monthly**	**Annual**
ZIP codes starting with 227 - 246						
Individual	$19.25	$219.45	$32.50	$370.50	$40.90	$466.25
Individual + 1	$37.40	$426.35	$63.15	$719.90	$79.55	$906.85
Family	$59.85	$682.30	$101.05	$1,151.95	$127.25	$1,450.65
All other ZIP codes						
Individual	$23.85	$271.90	$40.30	$459.40	$50.75	$578.55
Individual + 1	$46.40	$528.95	$78.35	$893.20	$98.65	$1,124.60
Family	$74.25	$846.45	$125.40	$1,429.55	$157.90	$1,800.05

Dental rates apply to members under age 65 and are subject to change. Rate information for members 65+ is available upon request.

To find a dentist near you, go to AnthemDentalAdmin.com and click on Enroll Now. Enter ZIP code, coverage type and date of birth. Click Get Quote, then Dentist Search.

Save time and money with smart dentist choices.

While all three plans allow you to go to any dentist, you can save money by choosing a network dentist.

	Network dentist	Non-network dentist
What you pay the dentist	• Your deductible. • The percentage that's not covered by your insurance.	• Your deductible. • The percentage that's not covered by your insurance. • The amount the dentist charges above the total amount we allow to be paid for a service.
Claims paperwork	• Your dentist submits claims to us. • We pay the dentist directly.	• You or your dentist may submit your claims to us. • We pay you or your dentist back for covered expenses.

You may pay more for dental care if you choose a non-network dentist. Here's why:

- **Network dentists** have agreed to payment rates for services and cannot charge you more than the agreed upon rate. If you have coinsurance or a deductible, you pay those amounts.
- **Non-network dentists** don't have a contract with us. They can charge you the difference between the total amount we allow to be paid for a service and the amount they normally charge for a service (plus your coinsurance or deductible).

Get started with Dental Prime.

It's easy to sign up. You can fill out a form online or by hand.

- Go to **AnthemDentalAdmin.com**.
- Or fill out and sign the Dental Prime application form. Then give your completed form to your agent or mail it to us at:

  Dental Enrollment Department
  P.O. Box 1193
  Minneapolis, MN 55440-1193

If you have any questions or need help with your application, talk to your Anthem representative or call us at 877-567-1807.

This is only a brief description of some plan terms and benefits. Please refer to your Dental Benefit Policy for more complete details including benefits, limitations and exclusions.

Dental exclusions

This is a partial list of dental plan exclusions. Please see the individual dental plan contract for a complete list.

New or unproven dental techniques or services · Dental services performed for cosmetic purposes · Dental services completed prior to the date the covered person became eligible for coverage · Services of anesthesiologists · Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care · Dental services performed other than by a licensed dentist, licensed physician, his or her employees · Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration · Orthodontic treatment services · Case presentations, office visits and consultations · Incomplete, interim or temporary services · Corrections of congenital conditions during the first 24 months of continuous coverage under this policy · Athletic mouth guards, enamel microabrasion and odontoplasty · Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening · Bacteriologic tests · Separate services billed when they are an inherent component of a dental service · Pediatric removable or fixed prosthetic appliances · Services for the replacement of an existing partial denture with a bridge · Oral hygiene instruction · Diagnostic casts · Incomplete root canals · Sinus augmentation · Recement space maintainers · Consultations · Orthodontic services

Blue View Vision℠

This vision option is available only when packaged with Dental Prime for Individuals and Families.

Blue View Vision can help you get the vision care you need – without breaking your budget.

Vision care isn't just for people who wear eyeglasses or contacts. Routine eye exams are an important part of protecting your vision and your overall health. Did you know?

- Eye exams can help detect other health problems like diabetes, high blood pressure and high cholesterol.[1]
- Eye diseases often have no warning signs. Because of that, many people don't know they might have a chance of their vision getting worse or of blindness.[2]
- One in four children has an undetected vision problem that can affect his or her ability to read and learn.[3]

Here are some reasons to choose Blue View Vision:

- **You have access to eye doctors close to you.**

  There are more than 30,000 eye doctors and more than 25,000 locations in the Blue View Vision network. It includes national retail stores like LensCrafters®, Sears Optical℠, Target Optical®, JCPenney® Optical, and most Pearle Vision® locations. If you don't already have a favorite, you can quickly find one online at anthem.com.

  If you use an eye doctor who's not in the network, you're still covered. Out-of-network benefits are different – see table on next page. You'll be asked to pay the full cost of the services you receive at your visit. Then mail a Blue View Vision claims form and your receipt to us and we'll pay you back for what the plan covers.

- **You'll get great in-network benefits.**

  Blue View Vision plans cover things like factory scratch coating on standard/basic eyeglass lenses at no extra cost. And children under age 19 can get UV-blocking Transitions® lenses and impact-resistant polycarbonate lenses at no extra charge.

- **It's simple to use your plan.**

  Just make an appointment with an in-network eye doctor and show your member ID card when you arrive.[4] If you don't have your member ID card, don't worry. Your doctor can look up your ID number online if he or she is part of the Blue View Vision network.

- **You save even more with extra discounts from in-network providers.**

  Want an eyeglass frame that costs more than your plan covers? You'll save 20% off the balance.[5] Want extra pairs of glasses, conventional contact lenses or prescription sunglasses? You'll save 15% to 40% on those. Plus, these discounts are unlimited and are in addition to your benefits for the coverage period.

- **You've got support after normal business hours.**

  Because you may see your eye doctor during evenings or weekends, we're open to help you at those times, too. You can call us Monday through Saturday, 7:30 a.m. to 11 p.m., and Sunday, 11 a.m. to 8 p.m., Eastern time.

Blue View Vision makes it easy and convenient to get vision care when you need it. And the extra discounts we offer help make it even more affordable for you. Check out the benefits and rates listed below.

Vision care services	Benefit frequency	Network services	Non-network reimbursement
Eye exam (with dilation as needed)	Once every 12 months	$20 copay	Up to $30
Standard plastic (CR39) lenses*	Once every 24 months		
Single vision		$20 copay	Up to $25
Bifocal		$20 copay	Up to $40
Trifocal (FT 25-28)		$20 copay	Up to $55
Contact lenses	Once every 24 months		
Elective (conventional and disposable)		$80 allowance	Up to $60
Non-elective		Covered in full	Up to $210
Frames	Once every 24 months	$130 allowance	Up to $45

*Factory scratch coating is covered at no extra cost. Polycarbonate and Transitions® lenses are covered for dependent children under 19 with no extra charge.

Premiums (Annual rates reflect a 5% discount when pre-paying annually)	Monthly	Annual
Individual	$8.29	$94.55
Individual + 1	$14.51	$165.47
Family	$23.22	$264.74

Rates are subject to change.

Keep in mind this is a brief overview of the vision plan's terms and features. Your Summary of Benefits will contain the details.

Ready to get started?

You can add Blue View Vision to your Dental Prime plan. Simply fill out the form online or by hand.

- Go to **AnthemDentalAdmin.com**.
- Or fill out and sign the Dental Prime application form. Then give your completed form to your agent or mail it to us at:

  Dental Enrollment Department
  P.O. Box 1193
  Minneapolis, MN 55440-1193

If you have any questions or need help with your application, talk to your Anthem representative or call us at 877-567-1807.

Vision plan benefit exclusions

We will not provide benefits for any of the following:

- Vision care services not specifically listed in the policy.
- If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed above.
- Sunglasses, safety glasses and accompanying frames
- Non-prescription or plano lenses
- Two pairs of glasses in lieu of bifocals
- Fitting or dispensing fees
- Non-elective contact lenses unless they are for the following diagnoses:
  - Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
  - High Ametropia exceeding -12D or +9D in spherical equivalent.
  - Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses

Your dental deductible, limitations, and waiting periods do not apply to vision care services in this rider.

1 All About Vision website: Why Are Eye Exams Important? (Jan 2013): allaboutvision.com/eye-exam/importance.htm
2 American Academy of Ophthalmology eyeSmart website: Symptom - Reduced Vision (January 2013) geteyesmart.org/eyesmart/symptoms/reduced-vision.cfm
3 Transitions Optical, Inc. Eye Didn't Know That! website: For Parents (2013): eyedidntknowthat.info/for-parents
4 Selecting out of network providers will result in higher costs to you. Make sure the provider you select is in-network to maximize your benefits.
5 Discounts do not apply on frames for which a manufacturer has imposed a no-discount policy.

Anthem Dental Prime for Individuals and Families

Coverage Details in Virginia

Anthem BlueCross BlueShield

Policy Terms

Renewability

This Policy will continue as long as you live, work, or reside in the service area and Anthem continues to offer this individual dental plan in the marketplace.

We can non-renew this Policy if all policies of the same form number are also not renewed. If we were to do this, notice would be sent to you at least ninety (90) days before your coverage would end. We would mail the notice to your last known address in our records. You would have the option to purchase other Anthem individual coverage currently available. The Grace Period provision does not apply if we have given you written notice that we will not renew this Policy. Termination of the Policy will result in loss of coverage for all Covered Persons. If the Policy is terminated, the rights of the Covered Persons are limited to Covered Services incurred before termination. Termination is without prejudice to any claim originating while the Policy was in force.

Canceling your policy

You may cancel this Policy at any time by written notice delivered or mailed to us; effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, we will return promptly the unearned portion of any Premium paid. The earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the Effective Date of cancellation. If you elect coverage and subsequently cancel your Policy, you and your Dependents will not be allowed to re-enroll in the Policy for a period of 12 – 24 months from the date your Policy was canceled.

Termination

When your coverage ends

Your coverage and that of your Dependents will end on the earliest of the following dates:

1. The end of the month in which you are no longer eligible;
2. The end of the month in which your Dependent is no longer a Dependent as defined in this Policy.
3. The last day of the month for which a Premium has not been paid, subject to the grace period, which is thirty-one (31) days from the date your premium is due;
4. The date the Policy ends. However, you may have your Policy reinstated if your Policy is terminated because you did not pay your premium within the grace period. Please see the provision below entitled Reinstatement for additional information about having your Policy reinstated.

The time of coverage termination is 11:59 p.m. on the termination date.

Dental - Maximums, Deductibles, Waiting Periods, Limitations and Exclusions

	Plan A	Plan B	Plan C
Maximums			
Annual Maximum	$500	$1,000	$1,250
Deductibles			
Deductible	None	$50 p/person	$50 p/person
Waiting Periods			
Diagnostic and Preventive Services	None	None	None
Basic Restorative	Not Covered	6 months	6 months
Endodontic Services	Not Covered	12 months	12 months
Periodontal Services	Not Covered	12 months	12 months
Oral Surgery Services	Not Covered	12 months	12 months
Major Restorative and Prosthodontic Services	Not Covered	Not Covered	12 months

Dental Limitations

- **Optional Treatment Plans:** If there are alternative treatments that have different costs, the final treatment decision is between you and your Dentist. We will cover the treatment that is the least costly and which is the most commonly performed treatment. You will be responsible to pay for the difference in cost between the Maximum Allowed Amount for the covered service and the optional treatment, plus any Deductible and/or coverage percentage for the covered benefit.
- **Reconstructive Surgery:** benefits will be provided for reconstructive surgery when dental care is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part, or when such dental care 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.
- **Dental orthodontic services** not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this Policy.
- Some services are an integral part of another completed covered service by the Policy. If the Dentist bills these procedures separately from the covered service, we will not pay for the separately billed procedures. You will then be responsible for any charge for the separately billed procedures and must pay your Dentist directly.

Diagnostic and Preventive Services

- **Oral Evaluations** – Any type of evaluation (checkup or exam) is covered two times per calendar year.
- **Bitewings** – Covered at one series of bitewings per 12-month period for Covered Persons through the age of 17; one series of bitewings per 24-month period for Covered Persons age 18 and over.
- **Full Mouth (Complete Series) or Panoramic** – Covered one time per 60-month period.
- **Periapical(s)** – four single X-rays are covered per 12-month period.
- **Occlusal** – Covered at two series per 24-month period.
- **Prophylaxis** – Any combination of this procedure and Periodontal Maintenance (See Periodontal Services) are covered two times per calendar year.
- **Fluoride Treatment** (Topical application of fluoride) – Covered one time per 12-month period for Dependent children through the age of 18.
- **Fluoride Varnish** – Covered one time per 12-month period for Dependent children through the age of 18.
- **Sealants or Preventive Resin Restorations** - Any combination of these procedures is covered one time per 12-month period for permanent first and second molars through the age of 15.

Basic Restorative Services

- **Amalgam Restorations** – one service per tooth surface per 24-month period.
- **Composite Resin Restorations** – one service per tooth surface per 24-month period.
- **Space Maintainers** – Covered one time per lifetime on eligible Dependent children through the age of 16 for extracted primary posterior (back) teeth.
- **Brush Biopsy** – Covered one time every 36 months for Covered Persons age 20 to 39. Covered one time per 12 months for Covered Persons age 40 and above.

Endodontic Services

- **Endodontic Therapy on Primary Teeth**
  - **Pulpal Therapy** is covered one time per tooth per lifetime.
  - **Therapeutic Pulpotomy** is covered one time per tooth per lifetime.
- **Endodontic Therapy on Permanent Teeth**
  - **Root Canal Therapy** is covered one time per tooth per lifetime.
  - **Root Canal Retreatment** is covered one time per tooth per lifetime.

Periodontal Services

- **Periodontal Maintenance** – Any combination of this procedure and dental cleanings (see Diagnostic and Preventive section) is covered two times per calendar year.

- **Periodontal Scaling & Root Planing** – Covered one time per 36 months if the tooth has a pocket depth of 4 millimeters or greater.
- **Full Mouth Debridement** – Covered one time per lifetime.
- **Complex Surgical Periodontal Care** – The following services are considered complex surgical periodontal services under this Policy. Only one complex surgical periodontal service is covered per 36-month period.
  - **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 is covered on natural teeth only**

Oral Surgery Services

- **Complex Surgical Extractions** – Surgical removal of third molars are only covered if the removal is associated with symptoms or oral pathology.
- **Other Complex Surgical Procedures** – the following are covered only when required to prepare for dentures and is a benefit covered once in a 60-month period:
  - Alveoloplasty
  - Vestibuloplasty
  - Removal of exostosis (per site)
  - Surgical reduction of osseous tuberosity
- **Surgical Reduction of Fibrous Tuberosity** – Covered one time per six months.
- **Intravenous Conscious Sedation, IV Sedation and General Anesthesia** – Covered when performed in conjunction with complex surgical services; will *not* be covered when performed with nonsurgical 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. A Pretreatment Estimate 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 us for further benefit consideration. You must submit a copy of the medical Explanation of Benefits (EOB) along with your claim to us.

  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 Policy within the noted limitations, maximums, deductibles and coverage percentages.

Please note:

1. Reconstructive surgery benefits will be provided for reconstructive surgery when such dental procedures are incidental to or follow 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.
2. Dental orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate is not covered.

Major Restorative Services

- **Gold Foil Restorations** – Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances. Covered one time per 24-month period.
- **Inlays** – Benefit will equal an amalgam (silver filling) restoration for the same number of surfaces.

- **Pre-fabricated or Stainless Steel Crown** – Covered one time per 60-month period for eligible Dependent children through the age of 18.
- **Onlays and/or Permanent Crowns** – Covered one time per seven year period per tooth for Covered Persons age 12 and older.
- **Recement Inlay, Onlay and Crowns** – Covered six months after initial placement.
- **Crown Repair** – Covered one time per 12-month period per tooth.
- **Restorative Cast Post and Core Build-Up, Including 1 Post per Tooth and 1 Pin per Surface** – Covered one time per seven-year period.

Prosthodontic Services

- **Tissue Conditioning** – Covered one time per 24-month period.
- **Reline and Rebase** – Covered one per 24-month period after six months from initial placement.
- **Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s)** – Covered one per six-month period after six months from initial placement.
- **Denture Adjustments** – Covered two times per 12-month period after six months following initial placement.
- **Partial and Bridge Adjustments** – Covered two times per 24-month period after six months from initial placement.
- **Removable Prosthetic Services (Dentures and Partials)** – Covered one time per seven-year period for covered persons age 16 or older.
- **Fixed Prosthetic Services (Bridge)** – Covered one time per seven-year period for covered persons age 16 or older.
- **Recement Fixed Prosthetic** – Covered one time per 12 months.
- **Single Tooth Implant Body, Abutment and Crown** – Covered one time per seven-year period for Covered Persons age 16 and over.

Dental Exclusions

We will not pay for services incurred for, or in connection with, any of the items below.

- Dental Services which a Covered Person would be entitled to receive for a nominal charge or without charge if this Plan were not in force under any Worker's Compensation Law, Federal Medicaid program, or Federal Veteran's Administration program. However, if a Covered Person receives a bill or direct charge for Dental Services under any governmental program, then this exclusion will not apply. Benefits under this Policy will not be reduced or denied because Dental Services are rendered to a Covered Person who is eligible for or receiving Medical Assistance.
- Dental Services or health care services not specifically covered under this Policy (including any hospital charges, prescription drug charges and Dental Services or supplies that are medical in nature).
- New or unproven dental techniques or services may be denied until there is an established scientific basis for recommendation.
- Dental Services performed for cosmetic purposes.
- Dental Services completed prior to the date the Covered Person became eligible for coverage.
- Services of anesthesiologists.
- Anesthesia services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a Dentist or an employee of the Dentist who is certified in their profession to provide anesthesia services.
- Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for nonsurgical or surgical dental care. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.
- Dental Services performed other than by a licensed Dentist, licensed physician or his or her employees.
- Dental Services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including: increasing vertical dimension, replacing

or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

- Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Orthodontic treatment services.
- Case presentations, office visits and consultations.
- Incomplete, interim or temporary services.
- Initial installation of an implant(s), full or partial dentures or fixed bridgework to replace a tooth (teeth) which was extracted prior to becoming a Covered Person under this Policy. EXCEPTION: This exclusion will not apply for any person who has been continuously covered for more than 24 months.
- Corrections of congenital conditions during the first 24 months of continuous coverage under this Policy.
- Athletic mouth guards, enamel microabrasion and odontoplasty.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited.
- Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
- Bacteriologic tests.
- Cytology sample collection.
- Separate services billed when they are an inherent component of another Dental Service.
- Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
- Interim or temporary removable or fixed prosthetic appliances (dentures, partials or bridges).
- Services for the replacement of an existing partial denture with a bridge.
- Additional, elective or enhanced prosthodontic procedures including, connector bar(s), stress breakers and precision attachments.
- Provisional splinting, temporary procedures or interim stabilization.
- Placement or removal of sedative filling, base or liner used under a restoration.
- Services or supplies that are medical in nature, including dental/oral surgery services performed in a hospital.
- Oral hygiene instruction.
- Occlusal procedures.
- Any charges that exceed the Maximum Allowed Amount.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Diagnostic casts.
- Amalgam or composite restorations placed for preventive or cosmetic purposes.
- Incomplete root canals.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Restorations placed for preventive or cosmetic purposes.
- Inlays, onlays and crowns placed for preventive or cosmetic purposes.
- Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.
- Recement space maintainers.
- Consultations.
- Orthodontic services.
- Brush biopsy.

Blue View Vision Details

Limitations

- One eye exam (with dilation as necessary) per 12-month period.
- One standard plastic pair of lenses, up to 55 mm (single vision, bifocal, trifocal) per 24-month period.
- One pair of contact lenses (elective or non-elective) per 24-month period.
- One frame per 24-month period.

Exclusions

We will not provide benefits for any of the following:

- Vision care services not specifically listed in this rider.
- If you receive elective or non-elective contact lenses, no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed above.
- For sunglasses, safety glasses and accompanying frames.
- For non-prescription or plano lenses.
- For two pairs of glasses in lieu of bifocals.
- For fitting or dispensing fees.
- Non-elective contact lenses unless they are for the following diagnoses:
  - Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
  - High Ametropia exceeding -12D or +9D in spherical equivalent.
  - Anisometropia of 3D or more.
  - Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

This brochure is intended to be a brief summary of coverage and is not intended to be a legal contract. The entire provisions of benefits and exclusions are contained in the Policy; the Policy has exclusions, limitations and terms under which the Policy may be continued in force or discontinued. For costs and complete details of the coverage, call 1-877-604-2158 for dental or 1-866-723-0515 for vision; or write Anthem Blue Cross and Blue Shield, P.O. Box 1115, Minneapolis, MN 55440-1115. In the event of a conflict between the Policy and this description, the terms of the Policy will prevail. Anthem Blue Cross and Blue Shield is not connected with or endorsed by the U.S. Government or the federal Medicare program.