Anthem
Health. Join In.

Anthem Dental

for individuals and families

Why dental care is a big part of your overall health

A healthy mouth is more than a great smile. Think about this: people who suffer from dental or gum disease are twice as likely to have heart illness or a stroke.[1] There's also research that links poor mouth health to high blood sugar (diabetes), lung disease and premature births.[2]

Regular dental check-ups can help find the early warning signs of certain health-related problems. That's just one reason why it means a lot to take good care of your teeth and gums.

A dental plan from Anthem Blue Cross and Blue Shield can help make it easy and affordable.

[1] American Academy of Periodontology: "Gum Disease Links to Heart Disease and Stroke," www.perio.org, 2008.
[2] National Institute of Dental and Craniofacial Research: "Oral Health in America," 2008.

Here's how the plan works

No health underwriting
You can sign up for this plan no matter what your health is – there are no medical questions to answer.

Save money with our network of dentists – or pick the dentist you want
To get the highest level of benefits, choose from our network of participating dentists. Of course, you're also free to choose a dental provider outside the network, but your part of the cost may be greater.

Preventive benefits are covered in full
When you visit a network dentist, you have no deductible or coinsurance to pay for any covered preventive or diagnostic service.

It's easy
When you visit a network dentist, there's almost no paperwork. Your claims will be filed for you, in most cases.* To reduce your paperwork even more, you can have your premium drafted from your bank account monthly with our automatic bank draft service. Or, you can choose some other payment method – we offer four times a year, two times a year and once a year billing.

Best of all
Anthem Dental for individuals and families is offered only from Anthem Blue Cross and Blue Shield, Virginia's largest health insurer.**

* This added feature is not guaranteed by your policy and can be modified or discontinued at our discretion.
** Anthem Market Research, October 2004.

Anthem Dental benefits

The charts on the next page show what Anthem Dental pays toward either in-network or out-of-network dental services. (But remember, in-network dentist fees are usually lower to start with, so you'll save even more money.)

It's easy to find a network dentist when you have access to one of the largest dental networks of its kind in Virginia. Go to anthem.com to find a dentist near you.

Monthly rates*

One adult under 50	$33.00	1st child with no adult applicant	$33.00
One adult 50 or older	$38.25	Each dependent child, up to 6 children	$21.25

*Subject to change.

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Preventive, diagnostic and radiographic benefits do not require a deductible or a waiting period. When you visit a network dentist, we cover these benefits at 100% of our allowable charge – your coinsurance is 0%. We cover 50% of the allowable charge when you visit a dentist outside the network.

Anthem Dental has an annual maximum benefit of $1,000 per covered person every calendar year the policy is in effect. This applies to preventive, restorative and complex benefits.

Diagnostic and preventive care

		Coinsurance	
Covered service	**Frequency**	**In-network**	**Out-of-network**
Diagnostic (oral exam)	2 per year	0%	50%
Set of full-mouth X-rays	Age 5 and over, 1 set every 3 years	0%	50%
Bitewing X-rays	1 per year *(not in same year as full-mouth X-ray)*	0%	50%
Routine cleaning with fluoride *(topical fluoride treatments for children under age 16)*	Limited to 2 cleanings per member, per year	0%	50%

Notes for diagnostic and preventive care

- Coverage begins on your plan effective date.
- The calendar year deductible of $50 per person, with a maximum of three deductibles per family ($150), is waived for diagnostic and preventive services.
- Coverage includes two oral examinations and two dental cleanings per member, per year.
- The total benefit for single and bitewing X-rays may not exceed the benefit for full-mouth X-rays.

This overview provides only a very brief description of some of the features of the plan. This is not the insurance contract and only the Policy provisions apply. Please refer to the applicable Certificate which sets forth, in more detail, the benefits, limitations and exclusions. If there are any conflicts between the terms of the Certificate and the information outlined above, the terms of the Certificate will prevail.

Restorative and complex services have waiting periods before services are covered. You pay a $50 annual deductible with an in-network dentist, and a separate $100 annual deductible when you go out-of-network. Restorative and complex services in- and out-of-network are reimbursed at 50% of the allowable charge.

		Coinsurance		Deductible	
Covered service	**Waiting period**	**In-network**	**Out-of-network**	**In-network**	**Out-of-network**
Restorative services (Fillings)	**6 months**	50%	50%	$50	$100
Simple extractions					
Adjunctive services (Emergency treatment of dental pain for minor procedure, general anesthesia with oral surgery)					
Oral surgery (Includes root removal, treatment of abscess)	**18 months**				
Prosthodontic services (Onlays, crowns, dentures)					
Endodontic services (Root canals)					
Periodontal services (Includes periodontal cleaning, scaling, root planing)					

How to apply for coverage

Complete and sign the enclosed application. Send in your application, initial premium, and $25 application fee to the address below. Your initial premium is your monthly rate times the number of months included in the billing option you choose (every 3 months for quarterly billing, every 6 months for semi-annual billing, etc.) Even if you take advantage of our bank draft option, you must include your first monthly payment.

Please note: Anthem Dental's billing cycle "resets" on June 1st of each year. Depending on when you apply and when your dental policy is effective, your chosen billing cycle may include the month of June. If so, your initial premium to be sent in with your application needs to only consist of the amount for months preceding June, plus the one-time $25 application fee.

If you send in your premium for June or months beyond, this premium will be applied to your account and be credited on your next bill.

Anthem Dental
P.O. Box 14046
Roanoke, Virginia 24038-4046

If you meet our eligibility requirements, and we receive your completed application, initial premium and $25 application fee by the 20th of the month, your earliest coverage effective date will be the 1st day of the following month. After the 20th, the earliest your coverage can begin is the 1st day of the second following month.

For a complete description of dental benefits, please contact your Anthem Blue Cross and Blue Shield sales representative. For a complete list of limitations and exclusions, see "Anthem Dental Coverage Details" (# 20891VAMENABS).

Anthem Dental Coverage Details

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Policy Terms

Coordination of Benefits

Anthem Blue Cross and Blue Shield policies all have a coordination of benefits provision. This provision explains that if you are issued an Anthem Blue Cross and Blue Shield Individual Dental Plan policy, and one of the persons covered by your Anthem policy is covered by a dental group plan, the dental group plan will have primary responsibility for the covered expenses of that family member. For any dependent children on your Anthem individual policy who are enrolled under another individual dental plan, the primary policy is the policy of the parent whose birthday (month and day) falls earlier in the calendar year. Parent birth year is not considered.

Eligibility

Individual Dental Plan coverage is available to those who:

- are under age 65, or 65 and older only if enrolled or enrolling in an Anthem Medicare Supplement plan;
- live in the Anthem Blue Cross and Blue Shield service area; and
- are not eligible for any group dental coverage.

Your spouse and dependent children are also eligible to apply. Dependent children must be:

- unmarried;
- under age 19 (or 23 if a full-time student); and
- not on active duty with any branch of the armed services.

This individual dental policy cannot be used as an employer-provided dental benefit plan. No employer of any person covered under this policy may pay any premium for this coverage, directly or indirectly, including through wage adjustment. “Employer” does not include a trade or business wholly owned by an individual, or individual and spouse, that has no other employees or that does not offer dental benefits to any other employees. Also, as it pertains to this provision, a church may purchase an individual dental policy if only purchasing it for one employee.

Renewability

Your policy is automatically renewed at the option of the Insured, as long as:

- premiums are paid in accordance with the terms of the policy;
- there is no documented pattern of abuse or misuse of our network by you;
- you make no fraudulent or material misrepresentation under the terms of this coverage, including on your application; and
- the Insured resides in Anthem’s service area.

We can refuse to renew this policy if all policies of the same form number are also not renewed. Any such action will be in accordance with applicable state and Federal laws.

Application fee

When you apply for Anthem Individual Dental, you must pay a $25 application fee which is non-refundable upon termination of your application or policy.

Canceling your policy

If you wish to cancel your policy, you must tell us by phone or in writing. Other than the application fee described above, we’ll refund any unused premium within 31 days after the cancellation date. Once you cancel your coverage, you cannot reapply for this coverage until 24 months after cancellation or lapse of this policy.

Termination

Coverage ends for a covered spouse upon divorce from the covered person in whose name the dental program was obtained (the Insured). Coverage will end for covered persons:

- if the required Premium is not paid when due, subject to a 31-day grace period;
- if there is a documented pattern of abuse or misuse of our dental network;
- at the Insured’s request;
- at the Insured’s death (a covered spouse or dependent may continue coverage under the dental program as long as the spouse or dependent contacts us within 31 days of the Insured’s death to arrange for continued coverage); or
- when he/she begins active duty with the armed services;

In addition, coverage ends for dependent children:

- at the end of the year a child turns 23 or
- when the child marries.

If the covered child is incapable of earning a living because of a mental or physical handicap, coverage for the child will continue as long as the Insured’s coverage is in force.

Limitations

Limitations & Exclusions

Like all dental coverage, this policy has limitations and exclusions.

“Limitations” are preset limits on covered services — for example, limits on the number of times you can receive a certain service over the life of your policy. “Exclusions” means services this policy does not cover. When we say “services,” we mean services and supplies. If you have questions about any of these limitations or exclusions or want to clarify the meaning of a dental or medical term stated below, please call your Anthem Sales Representative.

Limitations

Diagnostic Services

- 2 oral or periodontal evaluations (whether emergency or non-emergency) per calendar year

Radiographic Services

- 1 set of bitewing X-rays (not in same year as full mouth series X-rays) per calendar year;
- 1 full mouth series X-rays for covered persons age 5 and over every 3 calendar years; and
- 9 or more bitewing or periapical X-rays taken at one time will be considered a full mouth X-ray series; up to 4 individual periapical films, but not in the same year as a complete mouth X-ray series, (does not apply when rendered in conjunction with emergency treatment).

Preventive Services

- 2 dental cleanings, including periodontal cleanings each calendar year;
- 2 fluoride applications for covered persons under age 16 per calendar year;
- 2 space maintainers for covered persons under age 12 per lifetime; and
- 1 sealant for each unrestored permanent first and second molar for covered persons under age 16 per lifetime. There must be a lapse of a least 2 years from the time sealants are placed and the time a restoration is performed on the same tooth and surface for benefits to apply.

Restorative Services

- 1 amalgam or resin restoration (filling) per tooth per surface per calendar year. White-colored composite resin fillings will only be covered on anterior (front) teeth. If composite resin filings are done on back teeth, then you are responsible for the difference between our allowable charge and the dentist's charge for an amalgam filling.
- 1 pin retention per tooth per calendar year; and
- 1 stainless steel crown on each primary (baby) tooth per lifetime.

Endodontic Services

- 1 root canal; anterior, bicuspid or molar per tooth every 3 calendar years;
- 1 retreat of previous root canal; anterior, bicuspid, or molar per tooth per lifetime;
- 1 apicoectomy/periradicular surgery; anterior, bicuspid, molar, or additional root per root or tooth per lifetime;
- 1 retrograde filling per root or tooth per lifetime;
- Root canals are covered only on permanent teeth; and
- Therapeutic pulpotomy is covered only on primary (baby) teeth.

Periodontic Services

- 1 periodontal cleaning (applies to your 2 cleanings per year) per calendar year;
- 1 periodontal scaling and root planing per quadrant every two (2) calendar years;
- 1 gingivectomy or gingivoplasty per quadrant every three (3) calendar years;
- 1 periodontal osseous (bone) surgery per quadrant every three (3) calendar years; and
- 1 full mouth debridement per lifetime.

Prosthodontic Services

- Services for bridges, crown, and dentures are only covered for teeth extracted or missing after the dental policy's effective date, which includes initial placement only, unless for an existing bridge more than 5 years old;
- 1 adjustment or repair to partial or complete dentures per calendar year;
- 1 chairside relining of partial or complete dentures every 2 calendar years;
- 1 onlay, crown or bridge per tooth every 5 calendar years;
- 1 partial or complete denture per arch every 5 calendar years;
- 1 laboratory rebasing or relining of dentures per appliance every 5 calendar years;
- 1 crown repair per tooth per lifetime: and
- 1 crown recementation per tooth per lifetime.

Oral Surgery

- Use of anesthesia only in conjunction with surgical procedures; and
- 1 vestibuloplasty every 3 calendar years.

Adjunctive

- 1 palliative (emergency) treatment per calendar year; and
- Use of anesthesia only in conjunction with surgical procedures.

Exclusions

Anthem Individual Dental Plan does not cover:

- Services not listed or described in your policy as a covered service;
- Dental services that are covered under any other dental benefits plan under which a covered person is enrolled;
- Dental services with respect to congenital or developmental malformation or primarily for cosmetic purposes except as specified in your policy;
- Upgrading of serviceable dentistry;
- Services rendered prior to the covered person's effective date, and services rendered on or after the covered person's effective date that are directly related to services received by the covered person before the effective date;
- Services rendered after the date of termination of this policy;
- Dental pit/fissure sealants on other than first and second permanent molars;
- Diagnostic photographs;
- Dietary instruction or other counseling;
- Silicate restorations;
- Sedative fillings;
- Root canal therapy on other than permanent teeth;
- Pulp capping (direct or indirect);
- Separate charges for pulp vitality tests and bases and liners under restorations;
- Therapeutic pulpotomy on other than primary teeth;
- Guided tissue regeneration, including flap entry or re-entry and closure;
- Gingival curettage;
- Separate charges for irrigation or re-evaluation following periodontal therapy;
- Periodontal splinting and occlusal adjustments for periodontal purposes;
- Controlled release of medications to tooth crevicular tissues for periodontal purposes;
- Repositioning appliances or restorations necessary to increase vertical dimensions or restore or correct the occlusion;
- Services rendered for purposes other than to eliminate oral disease and/or replace covered missing teeth (mouth rehabilitation);
- Gold foil restorations;
- Inlays;
- Temporary dentures or temporary crowns, or duplicate dentures;
- Services to replace teeth that were lost or extracted prior to the policy's effective date;
- Services to replace non-functioning teeth;
- Fixed bridges when done in conjunction with a removable appliance in the same arch;
- Precision attachments for dental appliances;
- Tissue conditioning;
- Prefabricated resin crowns;
- Dental implants and associated services in conjunction with implants;
- Consultations (including telephone consultations), charges for failure to keep a scheduled visit, charges for completion of a claim form, or charges for providing information in connection with a claim;
- Occlusal guards and athletic mouth guards;
- Bleaching or whitening of discolored teeth;
- Behavior management or hypnosis;
- Prescription drugs and therapeutic injections;
- Separate charges for infection control procedures and procedures to comply with Occupational Safety and Health Administration (OSHA) requirements;
- Analgesics (nitrous oxide);
- Occlusal analysis;
- Tooth desensitizing treatments;

When coverage is available for the following services, these services require the performance of diagnostic X-rays six months prior to the earlier of (1) the request for predetermination of such services or (2) the date the services were rendered:

- more than one (1) crown;
- fixed prosthetic devices; or
- surgical extraction of impacted teeth.

If diagnostic X-rays are not preformed as specified here, the services listed are not covered.

- Services that we deem, in our sole discretion, to be experimental/investigative;
- Services that are not medically necessary as determined by us, in our sole discretion;
- Services of any type rendered in conjunction with the services of an attending Provider whose services are not covered by this policy;
- Services provided by your immediate family or by you; services rendered by a provider or provider's employee to a co-worker;
- Services covered under Federal or state programs (except Medicaid), or under any program to which the government contributes money. These programs include: Veterans Administration (VA) Hospitals; worker's compensation; and occupational disease law. This exclusion applies whether or not you waive your rights to payment. However, we will provide benefits once your benefits are exhausted under government-financed programs;
- Services for, or related to, cosmetic surgery and/or procedures, including routine complications thereof. Cosmetic surgery is a procedure performed to improve a person's appearance;
- Services not prescribed by or performed by or upon the direction of a provider licensed to do so;
- Services received from a dental or medical department maintained by or on behalf of an employer, a mutual association, labor union, trust, or similar person or group;
- Medical or dental services related to temporomandibular joint (TMJ) dysfunction, therapy or surgery, regardless of the reason such services are performed;
- Acupuncture;
- Anesthesia when used other than in conjunction with surgical services; and
- Separate charges for hospital visits or other facility charges.