

Basic terms and key information to help you get the most from your plan

What does “coordination of benefits” mean?

Our dental plans all have coordination of benefits as part of the plan services. This means that if you have two dental plans, we coordinate which plan pays for covered services first and which plan pays second. Here's how it works:

- If you have an Anthem Blue Cross and Blue Shield individual dental plan policy and you or one of the persons covered by your Anthem policy is also covered by a dental group plan, the dental group plan will be the main plan to pay for covered expenses of that member.
- For any dependent children on your Anthem individual policy enrolled under another individual dental plan, the main or first plan to pay for covered services would be the plan that belongs to the parent whose birthday (month and day only) falls earliest in the calendar year.

Who can get dental coverage (also called eligibility)?

Individual dental plan coverage is available to anyone who:

- Is under age 65; is 65 and older and enrolled or enrolling in an Anthem Medicare Supplement plan;
- Lives in the Anthem service area; and
- Cannot get (not eligible for) group dental coverage.

Your spouse and dependent children also can 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.

How does renewal work?

Your plan is automatically renewed when you or the covered member chooses to stay in the plan, as long as:

- Premiums are paid within the terms of the plan;
- You don't have a documented pattern of abuse or misuse of our provider network;
- You don't commit fraud or misrepresent yourself or materials under the terms of this coverage, including on your application; and
- The covered person lives in Anthem's service area.

We do not single anyone out for cancellation. We can refuse to renew your policy only if we don't renew policies for everyone who has the same plan (identified by the same plan number).

Any such action will be handled under the state and federal laws that apply.

What's the application fee?

When you apply, you must pay a \$25 application fee. This fee is non-refundable.

How do you cancel a plan policy?

If you wish to cancel coverage, you must tell us by phone or in writing. Other than the application fee, we'll refund any unused premium within 31 days after the date you cancel. Once you cancel your coverage, you cannot reapply until 24 months after cancellation or the plan ends.

When can coverage end?

There are three ways coverage can end.

1. Coverage will end for members:

- 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 request of the insured member who took out the coverage.
- At the member's death. A covered spouse or dependent may continue coverage as long as the spouse or dependent contacts us within 31 days of the member's death to ask to continue coverage.
- When the member begins active duty with the armed services;

2. Spouses: Coverage ends when the spouse is divorced from the covered member in whose name the dental program was obtained.

3. Coverage also ends for dependent children:

- At the end of the year a child turns 23; or
- When the child marries.

If the covered child can't earn a living because of a mental or physical handicap, coverage will continue as long as the insured's coverage does.

What are the policy limitations and exclusions?

Like all dental coverage, this plan has limitations and exclusions. “Limitations” are preset limits on covered services. One example is the limit set on the number of times you can get a service over the entire lifetime you are a member of this plan. “Exclusions” means services this plan does not cover. The word “services” includes both services and supplies. If you have questions about any of these or want to learn more about the meaning of a dental or medical term, please call your Anthem sales rep.

Limitations

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 (plastic coating on the grooves of the tooth) for each unrestored permanent first and second molar for covered persons under age 16 per lifetime. There must be a lapse of at 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.

Diagnostic services (checkups)

- 2 dental or periodontal (gum) checkups (whether emergency or non-emergency) per calendar year.

Radiographic services (X-rays)

- 1 set of bitewing X-rays per calendar year (but not in the same year as a series of full mouth X-rays); (Bitewing X-rays show the upper and lower back teeth and how the teeth touch each other in a single view.)
- 1 series of full mouth X-rays for covered persons age 5 and older 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 taken along with emergency treatment). (Periapical X-rays show the whole tooth from crown to the end of the root and bones.)

Restorative services (fillings)

- 1 amalgam or resin restoration per tooth per surface per calendar year. White-colored composite resin fillings will only be covered on anterior (front) teeth. If composite resin fillings are done on back teeth, then you pay 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 (inside of teeth)

- 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 (root end surgery when a root canal fails); 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 (to clean pulp chamber before root canal) is covered only on primary (baby) teeth.

Periodontic services (gums)

- 1 periodontal cleaning (tissues/gums around teeth) (applies to your 2 cleanings per year) per calendar year;
- 1 periodontal scaling and root planing per quadrant every 2 calendar years;
- 1 gingivectomy (gum surgery to remove tissue) or gingivoplasty (gum surgery to reshape healthy tissues) per quadrant every 3 calendar years;
- 1 periodontal osseous (bone) surgery per quadrant every 3 calendar years; and
- 1 full mouth debridement (to get rid of plaque and tartar) per lifetime.

Prosthodontic services (fix and replace teeth)

- 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 with surgical procedures; and
- 1 vestibuloplasty every 3 calendar years.

Adjunctive (needed for a medical condition, not a dental one)

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

Exclusions

Anthem Individual Dental Plan does not cover:

- Services not noted in your plan as a covered service;
- Dental services that are covered under any other dental benefits plan under which a covered member is enrolled;
- Dental services for congenital or developmental malformation or primarily for cosmetic purposes except as noted in your policy;
- Upgrading serviceable dentistry;
- Services given before the covered person's effective date;
- Services given 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 given after the date the policy ends;
- 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 after 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 given for purposes other than to get rid of 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 along 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), charges for not keeping a scheduled visit, completing a claim form, or charges for giving information along 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 procedures to control infection and to meet Occupational Safety and Health Administration (OSHA) requirements;
- Analgesics (nitrous oxide);
- Occlusal analysis;
- Tooth-desensitizing treatments;

When there is coverage, the following services require diagnostic X-rays six months before the earlier of these two things: (1) the request for predetermination of such services or (2) the date the services were given:

- More than one (1) crown;
- Fixed prosthetic devices; or
- Surgical extraction of impacted teeth.

If diagnostic X-rays are not done as noted above, the services listed are not covered. Services also are not covered if:

- We deem them to be experimental or investigative.
- They are not medically needed as determined by us, in our sole discretion.
- Given by, or along with, a provider whose services are not covered by this policy
- Given by your immediate family or by you; services given by a provider or provider's employee to a coworker.
- Covered under federal or state programs (except Medicaid), or under any program that the government contributes money to. These include: Veterans Administration (VA) Hospitals, worker's compensation and occupational disease law. This applies whether or not you waive your rights to payment. However, we will provide benefits once your benefits are all used under government- financed programs.
- For, or as part of, cosmetic surgery and/or procedure. This includes routine complications. Cosmetic surgery is performed to improve a person's appearance.

- Not prescribed by, or performed by, or under the direction of a provider licensed to do so.
- 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.
- Related to temporomandibular joint (TMJ) dysfunction, therapy or surgery, no matter what the reason such services are performed.
- Acupuncture.
- Anesthesia when used other than as part of surgical services; and
- There are separate charges for hospital visits or other facility charges.

Note: This individual dental policy cannot be used as an employer's dental benefit plan. No employer of any person covered under this policy may pay any premium for this coverage. That includes direct or indirect payment, including adjusting wages. "Employer" does not include a trade or business owned by an individual, or an individual and spouse who has no other employees or who does not offer dental benefits to any other employees. A church may buy an individual dental policy if only for one employee.