Anthem Blue Dental PPO Plan

For Individuals and Families

Anthem

Anthem Blue Cross and Blue Shield
700 Broadway
Denver, Colorado 80273
anthem.com

06-00029 (6/06)

Anthem

Colorado

Freedom to choose any dentist

Access to dental care at discounted fees

Wide range of dental services

Coverage for preventive care and diagnostic services begins on your policy effective date

PPO Dental Plan Coverage for Individuals and Families

We designed our Anthem Blue Dental PPO plan for individuals and families to help promote good oral hygiene and preventive care and to offer you convenient, affordable dental coverage. In other words, to make you smile!

The Anthem Blue Dental PPO plan features coverage for routine check-ups, X-rays and cleanings that begins the day your policy is effective.

You will be covered for fillings after six continuous months of coverage, and for major dental care after 12 continuous months of coverage, offering significant cost savings on procedures such as root canals, crowns and dentures.

With the Anthem Blue Dental PPO plan, you may visit any dentist you choose. However, your out-of-pocket costs will be lower if you use dentists in our network.

Please read this brochure for information about how our Anthem Blue Dental PPO plan works, including the plan's benefits, exclusions and limitations.

How the Plan Works

When you choose an in-network dental provider, you'll receive services at Anthem Blue Cross and Blue Shield's negotiated discounted rates. We still provide benefits when you choose an out-of-network provider; however, your out-of-pocket expenses may be higher, because our negotiated fees don't apply to out-of-network providers. You're responsible for any charges exceeding the stated benefit amount for both in-network and out-of-network dentists.

Your current dentist may already be an in-network provider. For an up-to-date listing of dental providers in our network, go to **anthem.com** and click the **Find a Doctor** link. It could save you money.

When visiting an out-of-network provider, we let you know up front how much the plan pays for covered services. This means you may calculate how much you'll have to pay once you've determined your dentist's fee for a specific procedure.

If your current dentist isn't in our network and you want him or her to join our network, please contact us at the address or phone number below:

Anthem Network Services
P.O. Box 9069
Oxnard, CA 93031-9069
888-209-7852

The following is an example of how Anthem Blue Cross and Blue Shield's negotiated rates may save you money. Negotiated rates may vary among in-network dental providers.

In-network Dentists	
If the billed amount is:	$850
And Anthem's negotiated rate is:	$430
Anthem will pay 50% of the negotiated rate:	$215*
You pay the difference between the negotiated rate and what Anthem pays.	$215

Out-of-network Dentists	
If the billed amount is:	$850
Anthem will pay the amount specified in the benefit schedule:	$347
You pay the difference between the billed amount and the scheduled benefit.	$503

*This assumes any deductible has been met and you haven't reached your annual maximum. Billed amounts and negotiated rates in the above table were determined by using an example of in-network and out-of-network rates for dentists in the Denver, Colorado, area (ZIP code 80273) for American Dental Association procedure code D2750. The information in this example is from Anthem Blue Cross and Blue Shield's 2005 claims data. Negotiated rates may vary by in-network dentists, based on their contractual relationship with Anthem.

Calendar-year Deductible

You're responsible for a $50 per person deductible per calendar year, with a maximum of three deductibles per family ($150), before you receive benefits for covered services. The calendar-year deductible is waived for preventive and diagnostic services when they're provided by an in-network dentist.

Calendar-year Maximum Benefit

Your Anthem Blue Cross and Blue Shield dental benefits are limited to $1,000 for each enrolled member during a calendar year.

Waiting Periods

Coverage for preventive and diagnostic care begins on your plan effective date. Coverage for basic care begins after six continuous months of coverage, and coverage for major care begins after 12 continuous months of coverage.

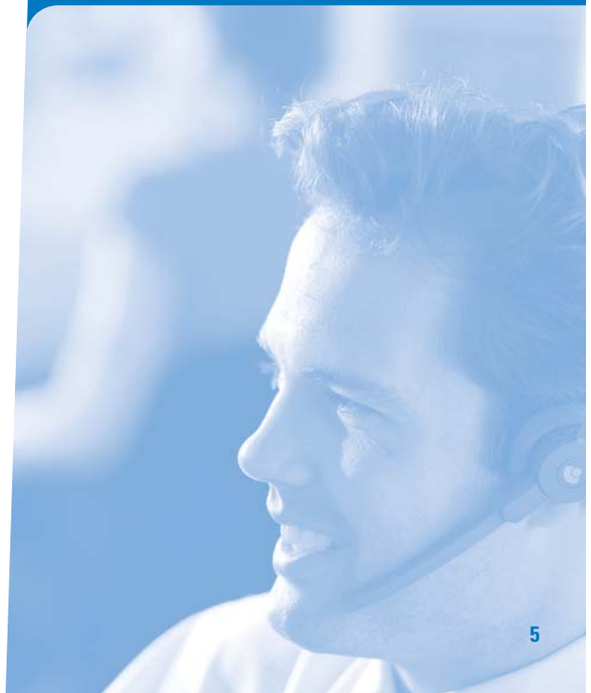
Customer Service

Our professional customer service representatives are available to help you and answer questions about your plan. The toll-free number is listed on the dental plan ID card you'll receive once you're enrolled.

Benefit Schedules

To use our schedules, check your dentist's fee and then determine how much the plan pays. You can then easily calculate what you'll pay for a specific service after you meet your deductible. The plan pays either the specified amount or the actual amount charged by your dentist, whichever is lower.

Customer service representatives are available to help you and answer questions about your plan.



Preventive and Diagnostic 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 preventive care and diagnostic services when a member uses an in-network dentist.
- 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.

Procedure	Plan Pays	
	In-network	Out-of-network
Periodic oral exam (limited to 2 per member per year)	100%	$26.00
Bitewing X-rays (single film)	100%	$16.00
Bitewing X-rays (2 films)	100%	$27.00
Single (periapical) X-rays (first film)	100%	$14.00
Single X-rays (each additional film)	100%	$14.00
Bitewing X-rays (4 films)	100%	$36.00
Full-mouth X-rays (limited to 1 set every 5 years)	100%	$65.00
Routine cleaning (limited to 2 per adult[1] per year)	100%	$54.00
Routine cleaning (limited to 2 per child[2] per year)	100%	$38.00
Cleaning with fluoride (limited to 2 per child per year)	100%	$57.00
Sealants per tooth	100%	$32.00

[1] Adult: Any person or dependent 19 years of age or older covered by the Anthem Blue Dental PPO plan

[2] Child: Any person or dependent 18 years of age or younger covered by the Anthem Blue Dental PPO plan

Rates are effective as of July 1, 2006, and are subject to change.

Basic Dental Care

- Benefits begin after coverage has been effective for six continuous months.
- The calendar-year deductible of $50 per person, with a maximum of three deductibles per family ($150), must be satisfied before we will pay any benefits.

Procedure	Plan Pays	
	In-network	Out-of-network
Filling (1 surface)	80%	$62.00
Filling (2 surfaces)	80%	$78.00
Filling (3 surfaces)	80%	$96.00
Filling (4 or more surfaces)	80%	$118.00

Rates are effective as of July 1, 2006, and are subject to change.

Major Dental Care

- Benefits begin after coverage has been effective for 12 continuous months.
- The calendar-year deductible of $50 per person, with a maximum of three deductibles per family ($150), must be satisfied before we will pay any benefits.

Procedure	Plan Pays	
	In-network	Out-of-network
Extraction (erupted tooth or exposed root)	50%	$42.00
Surgical removal of erupted tooth	50%	$74.00
Removal of impacted tooth (soft tissue)	50%	$74.00
Removal of impacted tooth (partial bony)	50%	$106.00
Removal of impacted tooth (complete bony)	50%	$124.00
Four or more scaling/root planing per quadrant	50%	$104.00
Gingivectomy (1 to 3 teeth per quadrant)	50%	$91.00
Gingivectomy (4 or more contiguous teeth per quadrant)	50%	$152.00
Anterior root canal (1 canal)	50%	$261.00
Bicuspid root canal (2 canals)	50%	$279.00
Molar root canal (3 canals)	50%	$333.00
Crown (porcelain fused to high noble metal)	50%	$328.00
Pontic (porcelain fused to high noble metal)	50%	$328.00
Upper partial denture cast metal with resin	50%	$475.00
Complete maxillary denture	50%	$510.00

Rates are effective as of July 1, 2006, and are subject to change.

Eligibility and Enrollment

To be eligible for enrollment, you must meet all of the following requirements:

- A resident of the state of Colorado who properly applies for coverage and is accepted by Anthem Blue Cross and Blue Shield.
- A resident of the United States for at least six months.
- Not enrolled under any other Anthem Blue Cross and Blue Shield Individual or Group dental plan.

Plus you must be **one** of the following:

- Age 64 or younger.
- The applicant's lawful spouse, age 64 or younger.
- The applicant's unmarried child up to age 19.
- The applicant's unmarried child and financial dependent, through age 24.

Plan Effective Date

You may choose your effective date—either immediately upon approval, the first of the month following approval or a later date. Your plan effective date will be printed on the dental plan ID card you'll receive once your enrollment is approved.

Benefits for major dental care begin after coverage has been effective for 12 continuous months.

Anthem Blue Dental PPO Plan Rates Effective July 1, 2006	
One adult	$36.91
Two adults	$73.82
Adult with one child	$58.94
Adult with two children	$80.97
Adult with three or more children	$103.00
Family (one child)	$95.85
Family (two children)	$117.88
Family (three or more children)	$139.91
One child	$22.03
Two children	$44.06
Three or more children	$66.09

These are monthly premium rates. For quarterly rates, multiply the monthly rate by three.

Terms of Coverage

Coverage under the Anthem Blue Dental PPO plan remains in force as long as the required premiums are paid on time and as long as you remain eligible for coverage. Coverage ceases when a member becomes ineligible due to divorce or a change in dependent status. (In the case of divorce and over-age dependents, Anthem Blue Cross and Blue Shield will offer you a similar plan.) Anthem may change the premiums for this plan after providing you with 30-day advance written notice. Anthem will not change the premium schedule for this plan on an individual basis but only for all members in your class and plan.

Exclusions and Limitations

For complete details about plan benefits, limitations and exclusions, please refer to the certificate. In the event of a conflict between anything printed in this brochure and the certificate, the terms of the certificate will prevail.

Diagnostic and preventive services:

- Oral evaluations: Limited to two per calendar year in any combination of the following types of evaluations: periodic, limited, comprehensive, detailed/extensive and periodontal evaluations.
- Bitewing radiographs (one set of up to four films): Limited to once per calendar year.
- Vertical bitewings (seven to eight films): Up to eight films will be covered in any five-year period. Benefits are not payable if performed on the same date of service as a panoramic film or full-mouth radiographs.
- Periapical X-rays: Limited to four films per calendar year. Benefits are not payable if performed on the same date of service as a panoramic film or full-mouth radiographs.
- Complete series (panoramic film or full-mouth radiographs): Limited to once every five years. Complete series of radiographs include bitewings and will count as one occurrence for that calendar year. Nine or more radiographs in any combination of periapical, occlusal and bitewing radiographs will be considered a complete series.
- Adult prophylaxis: Limited to a total of two per calendar year, singly or in combination with a periodontal maintenance procedure. Allowance includes cleaning, scaling and polishing the teeth.
- Child prophylaxis: Limited to two per calendar year for children up to age 16. Allowance includes cleaning, scaling and polishing the teeth.
- Fluoride treatments (topical application): Limited to two per calendar year for dependent children up to age 19.
- Sealants for unrestored permanent first and second molars: Limited to one application per tooth and one replacement per tooth if the replacement is performed at least 36 months after initial application. Covered only for dependent children up to age 16.
- Space maintainers: Limited to once per quadrant per lifetime for children up to age 16. Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes initial prosthesis only and all adjustments within six months of placement.
- Replacement space maintainers: Covered only after 12 months have passed since initial placement.
- Consultations: Diagnostic service provided by a dentist other than the practitioner providing treatment is limited to one per calendar year.
- Office visit for observation: Limited to two visits per calendar year in combination with other covered oral evaluations. Not covered when associated with other services or procedures.
- Amalgam restorations: Limited to once per surface per tooth every 24 months. Replacement of existing restoration is allowed no more than once every 24 months.
- Composite resin restorations: Limited to once per surface per tooth every 24 months. Replacement of existing restoration is allowed no more than once every 24 months. Benefits for composite resin restorations on posterior permanent teeth and primary teeth will be based on the maximum allowable amount for the corresponding amalgam restoration.

- Root canal therapy: Covered services include a treatment plan, clinical procedures, postoperative radiographs and follow-up care. If multiple endodontic treatments are necessary on the same tooth within a period of one year, the allowance will be made for only one procedure. Root canal therapy is limited to one initial treatment per tooth per lifetime and one re-treatment per tooth per lifetime. Coverage is for permanent teeth only.
- Apicoectomy/periradicular services: The maximum allowable amount for apicoectomy/periradicular services includes reimbursement for the removal of granulation tissue at the apex of the tooth. No additional benefit is available for the removal of granulation tissue at the apex of the tooth if billed separately from the apicoectomy/periadicular service.
- Retrograde fillings are not covered
- Therapeutic pulpotomy (excluding final restoration): Coverage is for primary teeth only.
- Pulp capping, direct and indirect: Coverage is for permanent teeth only.
- Gross pulpal debridement: Not payable if performed in conjunction with root canal treatment or palliative emergency treatment.
- Gingivectomy or gingivoplasty: Limited to once per quadrant in any three years. When performed in conjunction with a crown build-up, post and core, or with a crown, the gingivectomy or gingivoplasty is considered part of that procedure, and there will be no additional benefit.
- Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis (removal of subgingival and/or supragingival plaque and calculus): Limited to once per lifetime.
- Periodontal scaling and root planing: Limited to once per quadrant every 24 months.
- Periodontal maintenance procedure: Covered only when following active periodontal therapy. Limited to two procedures per calendar year, singly or in combination with routine prophylaxis.
- Crowns, inlays, onlays: Benefits for crowns, inlays and onlays are limited to once per tooth in any seven-year period, whether placement was under this policy or under any prior dental coverage, even if the original crown was stainless steel or temporary. Laboratory-fabricated restorations and crowns are covered only when the tooth cannot be restored with routine filling material.
- Re-cementing of crowns/inlays/onlays: Limited to a lifetime maximum of once per crown/inlay/onlay.
- Crown/onlay repairs: Limited to once per crown/onlay in any seven-year period.
- Stainless steel crowns (for primary teeth only): Benefits are not provided for stainless steel crowns when used as a temporary crown.
- Removable complete (immediate or permanent) and partial dentures, but only if the tooth/teeth being replaced were extracted after the member's effective date: Limited to once in seven years. Benefits are available for the replacement of complete or partial dentures but only if the prosthesis is seven years old or older and cannot be made serviceable. Benefits are payable for either complete or immediate dentures, but not both.
- Denture adjustments: Limited to once per year per denture.
- Denture repairs: Limited to once per denture in a seven-year period.
- Re-cementing a bridge: Limited to a lifetime maximum of once per bridge.
- Post and core: Limited to once per tooth in a seven-year period, after root canal therapy.

- Core buildup: Limited to once per tooth in a seven-year period.
- Bridge repair: Limited to once per bridge in a seven-year period.
- Amounts exceeding the cost of the material are not covered if a tooth or teeth can be restored with amalgam (with the exception of composite resin on anterior teeth) and other material is used. Anterior teeth exhibiting pathology eligible for composite restorations are central incisors, lateral incisors, cuspids and the facial surface of bicuspids are not covered.
- Services provided before or after the term of this coverage: Services received before your effective date under this policy or incurred after the termination date of this coverage, except as specified elsewhere in this policy, are not covered.
- Professional services received from a person who lives in your home or who is related to you by blood, marriage or adoption are not covered.
- Cosmetic dentistry: Any services performed for cosmetic purposes, including, but not limited to, external bleaching, bleaching of non-vital discolored teeth, veneers, crowns on teeth not exhibiting pathology and facings on crowns on posterior teeth, are not covered, unless they are for correction of functional disorders or as a result of an accidental injury occurring while you were covered for dental benefits under this policy are not covered.
- Replacement of an existing fixed or removable prosthesis for which benefits were paid if replacement occurs within seven years of the original placement, unless the prosthesis is being used during the healing period for recently extracted anterior teeth, is not covered.
- Replacement of crowns, inlays, onlays and laboratory-fabricated restorations if replacement occurs within seven years of the original placement is not covered.
- Lost or stolen dentures or appliances: Replacement of existing full or partial dentures or appliances that have been lost or stolen is not covered.
- Charges for any duplicate prosthetic device or appliance, or for a "spare" set of dentures or any other duplicate appliance such as, but not limited to, removable orthodontic retainers, is not covered.
- Any prescribed drugs, pre-medication or analgesia, including charges for nitrous oxide or any similar local anesthetic when the charge is made separately from a covered service are not covered.
- Replacement of existing restorations for any purpose other than the treatment of pathology or decay is not covered.
- The extraction of immature erupting third molars and nonpathologic, asymptomatic third molars is excluded. Third molar extractions are not covered under age 16.
- Any services related to the diagnosis or treatment by any method of any condition related to the jaw joint (temporomandibular joint or TMJ) or associated musculature, nerves and other tissues, regardless of the reason(s) such services are necessary, are not covered.
- Prosthetics for patients under 16 years of age, including, but not limited to, fixed bridges, dentures, removable partials, crowns, inlays and onlays, are not covered.
- Teeth lost before coverage under this policy are not eligible for prosthetic replacement unless the prosthetic replacement replaces one or more eligible natural teeth lost during the term of this coverage.
- Orthodontic services: Cephalometric film, braces, appliances and all related services are not covered.

How to Enroll

If you're a new member and want dental coverage ONLY:

- Complete and sign the attached application.
- Determine your premium rate and your initial payment (see Payment Options on page 16).
- Send the application, your first payment and your completed Payment Options Form to your agent or to Anthem Blue Cross and Blue Shield at the address below.
- You also may pay your initial monthly or quarterly premium by automatic deduction from your checking account, MasterCard® or Visa®.

If you're currently enrolled in an Anthem Blue Cross and Blue Shield health care benefits plan and want to ADD dental coverage:

- Complete the attached application.
- Determine your premium rate and your initial payment.
- Determine your payment option—it must be the same as for your health coverage. If you're using monthly checking account deduction, you must still send a check for the first month's premium with the application.
- Send the application with a check for the first month's premium to your agent or to:

Anthem Blue Cross and Blue Shield
Individual Product Administration
P.O. Box 173334
Denver, CO 80217-9411

Anthem

Colorado
Anthem Blue Individual PPO
Dental Plan Enrollment Application

If Anthem approves my application, please assign the following effective date: *(select one)*

- ☐ Immediately upon approval, or
- ☐ The 1st of the month following approval, or
- ☐ _____
  Specify a later date (for example, the 15th of the month following approval)

If you are an Anthem Blue Cross and Blue Shield subscriber with group health coverage, please enter your Anthem I.D. number here:

Anthem I.D. Number

Applicant Information *Applicant must complete this section. Please print.*

Last Name	First Name	MI	Social Security Number

Home Phone Number	Business Phone Number	Gender	Marital Status	Age	Date of Birth (mm/dd/yy)
( )	( )	☐ M ☐ F	☐ Single ☐ Married		

Home Address (Must be complete. A P.O. box is not acceptable.)			Billing Address (if P.O. box or different from home address)		
City	State	ZIP Code	City	State	ZIP Code

Spouse to be Insured *Signature required below*

Last Name of Spouse	First Name of Spouse	Gender	Date of Birth (mm/dd/yy)	Social Security Number
		☐M ☐ F		

Children to be Insured

	NAME (first and last name)	GENDER	DATE OF BIRTH (mm/dd/yy)	SOCIAL SECURITY NUMBER
1.		☐M ☐ F		
2.		☐M ☐ F		
3.		☐M ☐ F		
4.		☐M ☐ F		

Signatures (required)

If any family member listed above is a minor, I (Applicant) accept full legal and financial responsibility for the coverage and information provided on this application. (If the responsible adult is not the natural parent but is the legal guardian, or is under court order to provide coverage, please submit substantiating court papers.) I (Applicant) understand that coverage is subject to all conditions and provisions specified in the policy. I (Applicant) understand that receipt of payment with this application does not create Anthem Blue Cross and Blue Shield coverage. Coverage will be effective only upon approval by Anthem.

Signature of Applicant/Parent or Legal Guardian	Today's Date	Signature of Applicant's Spouse	Today's Date
X		X	
Signature of Applicant's Dependent Age 18 or Over	**Today's Date**	**Signature of Applicant's Dependent Age 18 or Over**	**Today's Date**
X		X	

Agent Information

Name of Agent (print)	Agent Tax ID Number	Signature of Agent	Today's Date

FOR ANTHEM USE ONLY

Group Number	Certificate Number	Effective Date	Area	By	Date

Mail your completed application to Anthem Blue Cross and Blue Shield with a check for the first month's premium to your agent or to: Anthem Blue Cross and Blue Shield, Individual Product Administration, P.O. Box 173334 Denver, CO 80217-9411. Thank you!

06-00028 (6/06)

Payment Options

Initial premium payment options: You have three options to choose from to pay your first month's premium:

- Send a paper check
- Provide payment via electronic check
- Use your credit/debit card

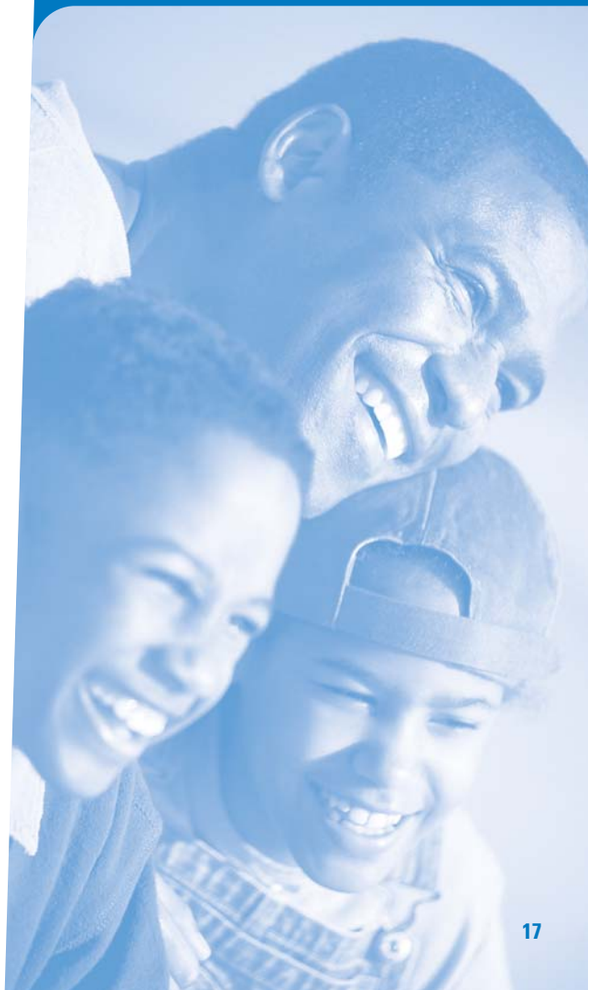
Complete instructions are provided on the Payment Options Form.

Future payments options: Anthem Blue Cross and Blue Shield provides the following convenient payment options for your future payments:

- Monthly checking account automatic premium payment
- Monthly paper billing
- Monthly credit/debit card
- Bi-monthly paper billing
- Quarterly paper billing

The Payment Options Form provides complete information and instructions for each payment method. Please review carefully, make your selections for initial and future payments, fill out the appropriate information and submit the completed Payment Options Form with your application.

Flexible and convenient—
You may choose from three payment options and five billing options.



Payment Options

Applicant Social Security or ID Number

Payment Method (Premium payment required. Please choose from A or B.)

A. Please choose from the options below for your initial premium payment:

☐ Paper Check* ☐ Electronic Check ☐ Credit/Debit Card

B. Please choose from the following options for future payments.

☐ Monthly Checking Account Automatic Premium Payment *(complete Section below)* ☐ Monthly Credit/Debit Card *(complete Section below)* ☐ Bi-monthly Paper Billing

☐ Monthly Paper Billing ☐ Quarterly Paper Billing—submit the three-month premium

Monthly Checking Account Automatic Premium Payment

By providing your check information to the right, you authorize us to electronically debit your bank account. If you have not sent in an initial premium payment from choice A, your bank account will be debited one month's premium the day after approval. This will include all products selected, including dental and/or life. Subsequent premium amounts will be debited on the day you request below.

Requested debit day: ☐☐ **(1st to 28th of each month)**
If no date is requested, your premiums will be debited on the first of each month.

Provide your routing and account numbers here.

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of Anthem Blue Cross and Blue Shield, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during underwriting, and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents or moving my residence. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem Blue Cross and Blue Shield to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross and Blue Shield premiums. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. **NOTE:** Should your withdrawal not be honored by your bank, you will automatically be removed from monthly checking account automatic premium payment and will be billed monthly.

You will incur a $25 service charge for any withdrawal not honored.

Authorized Signature *(as it appears in the financial institution's records)*	Account Holder Name PRINT	Date
X		

Monthly Credit/Debit Card

As a convenience to me, I request and authorize you to charge my card for monthly recurring premiums on each due date. I understand that the initial payment amount may vary as a result of change(s) during underwriting, and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents or moving my residence. The amount may also change as outlined in my policy. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage.

☐Visa ☐ MasterCard [☐Discover]

Card Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ *(13 or 16 digits)*

Expiration Date: ☐☐/☐☐

Cardholder ZIP Code: ☐☐☐☐☐–☐☐☐☐

Authorized Signature *(as it appears on the credit card)*	Cardholder Name *(as it appears on the credit card)* PRINT	Date
X		

Electronic Check

In lieu of sending a paper check, we can submit this same information electronically. You will need to complete the information below. We require an exact amount and check number of the check you are using. Please void this check to prevent future use.

Account Holder Name PRINT	Bank Routing Number	Account Number	Amount	Check Number
			$	

** By sending your paper check, you authorize us to convert your check to an electronic fund transfer. If you are approved for coverage, your bank account will be debited for the amount indicated on the check. If you do not qualify for coverage, your check will not be submitted for a funds transfer. Please be aware that your check will not be returned to you.*