

# Anthem Blue Dental PPO Plan for Individuals and Families

## For dental benefits you can smile about!

### Why dental care is important to your overall health...

Consider this: people who suffer from periodontal disease are twice as likely to have heart disease or a stroke.<sup>1</sup> And there's also research linking poor oral health to diabetes, lung disease and premature births.<sup>2</sup>

Fortunately, regular dental check-ups can help detect the early warning signs of certain health-related issues. That's just one reason why it's so important to take good care of your teeth and gums. And an Anthem Blue Dental plan from Anthem Blue Cross and Blue Shield can help make it easy and affordable.

<sup>1</sup> American Academy of Periodontology: Gum Disease Links to Heart Disease and Stroke, perio.org, 2008.  
<sup>2</sup> National Institute of Dental and Craniofacial Research: Oral Health in America, 2008.

### What Anthem Blue Dental coverage helps pay for:

- Routine check-ups, X-rays and cleanings. Coverage begins on your plan effective date and there's no deductible for these services when provided in-network.
- Basic dental care like fillings and extractions. Coverage begins after you meet a \$50 annual deductible (up to \$150/family) and have 6 months of continuous coverage.
- Major dental work, for example root canals and crowns. You'll be covered after 12 months of continuous coverage and your deductible is met.
- Both in-network and out-of-network dental care. For the best savings, you should choose in-network dentists and specialists.
- Up to \$1,000 of dental services per member, per year, after any deductibles or coinsurance you might have.

### Anthem Blue Dental benefits-at-a-glance...

The charts on the next page show what Anthem Blue 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 you even more money.)

#### Monthly rates\*

One adult	\$27.00	Family (two children)	\$84.00
Two adults	\$54.50	Family (three or more children)	\$106.00
Adult with one child	\$42.00	One child	\$15.00
Adult with two children	\$56.50	Two children	\$29.50
Adult with three or more children	\$79.00	Three or more children	\$51.50
Family (one child)	\$69.00		

\*Subject to change.

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It's easy to find a network dentist when you have access to the largest dental network of its kind in Nevada! Go to [anthem.com](http://anthem.com).

## DIAGNOSTIC AND PREVENTIVE CARE

Procedure	Plan Pays	
	In-network	Out-of-network
Periodic oral exam (limited to 2 per member per year)	100%	\$15.00
Bitewing X-rays (single film)	100%	\$9.00
Bitewing X-rays (2 films)	100%	\$14.00
Single (periapical) X-rays (first film)	100%	\$9.00
Single X-rays (each additional film)	100%	\$9.00
Bitewing X-rays (4 films)	100%	\$21.00
Full-mouth X-rays (limited to 1 set every 3 years)	100%	\$38.00
Routine cleaning (limited to 2 per adult <sup>1</sup> per year)	100%	\$40.00
Routine cleaning (limited to 2 per child <sup>2</sup> per year)	100%	\$26.00
Cleaning with fluoride (limited to 2 per child per year)	100%	\$36.00
Topical fluoride only (limited to 2 per child per year)	100%	\$12.00

<sup>1</sup> Adult: Any person or dependent 19 years of age or older covered by the Anthem Blue Dental PPO plan.

<sup>2</sup> Child: Any person or dependent 18 years of age or younger covered by the Anthem Blue Dental PPO plan.

Rates are subject to change without notice.

### 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 ONLY when the member receives preventive and diagnostic care services from 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 (\$38).

## BASIC DENTAL CARE

Procedure	Plan Pays
Filling, permanent tooth (1 surface)	\$42.00
Filling, permanent tooth (2 surfaces)	\$54.00
Filling, permanent tooth (3 surfaces)	\$65.00
Filling, permanent tooth (4 or more surfaces)	\$78.00
Extraction, simple (erupted tooth or exposed root)	\$39.00
Surgical removal of erupted tooth	\$72.00
Removal of impacted tooth (soft tissue)	\$100.00
Removal of impacted tooth (partial bony)	\$120.00
Removal of impacted tooth (complete bony)	\$150.00

Rates are subject to change without notice.

### Notes for Basic Dental Care

- Coverage begins after your plan has been in effect for six continuous months.
- These services are subject to an annual deductible of \$50 (limited to \$150 per family).

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 Certificate of Coverage ("Certificate") 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.

## MAJOR DENTAL CARE

Procedure	Plan Pays
Scaling/root planing per quadrant	\$43.00
Gingivectomy (1 to 3 teeth per quadrant)	\$30.00
Gingivectomy (4 or more contiguous teeth per quadrant)	\$97.00
Root canal (1 canal)	\$127.00
Root canal (2 canals)	\$155.00
Root canal (3 canals)	\$205.00
Crown (except stainless steel)	\$225.00
Stainless steel crown	\$55.00
Pontic	\$225.00
Complete denture (upper or lower)	\$300.00
Partial denture (upper or lower)	\$275.00
Denture reline (chairside)	\$55.00
Denture reline (lab)	\$80.00

Rates are subject to change without notice.

### Notes for Major Dental Care

- Coverage begins after your plan has been in effect for 12 continuous months and you have satisfied the annual plan deductible of \$50 (limited to \$150 per family).

## How to apply for coverage

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

- Complete and sign the Anthem Blue Individual PPO Dental Plan Enrollment Application.
- Determine your premium rate and your initial payment.
- Send the application and first payment 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 applying for Anthem Blue Cross and Blue Shield health care coverage and dental coverage:

- Complete and sign the Anthem Blue Individual PPO Dental Plan Enrollment Application.
- Once completed, fax both sides of the application to Anthem Individual Membership at 303-764-7282 or 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 the address below.

### 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 Anthem Blue Individual PPO Dental Plan Enrollment 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 9051  
Oxnard, CA 93031-9051

For a complete description of dental benefits, limitations and exclusions, please contact your Anthem Blue Cross and Blue Shield sales representative.



NEVADA

### 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

<b>Applicant Information</b> <i>Applicant must complete this section. Please print.</i>											
Last Name			First Name			MI		Social Security Number			
Home Phone Number (    )		Business Phone Number (    )		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Age	Date of Birth (mm/dd/yy)			
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			
<b>Spouse to be Insured</b> <i>Signature required below</i>											
Last Name of Spouse			First Name of Spouse			Gender <input type="checkbox"/> M <input type="checkbox"/> F		Date of Birth (mm/dd/yy)		Social Security Number	
<b>Children to be Insured</b>											
NAME (first and last name)				GENDER		DATE OF BIRTH (mm/dd/yy)		SOCIAL SECURITY NUMBER			
1.				<input type="checkbox"/> M <input type="checkbox"/> F							
2.				<input type="checkbox"/> M <input type="checkbox"/> F							
3.				<input type="checkbox"/> M <input type="checkbox"/> F							
4.				<input type="checkbox"/> M <input type="checkbox"/> F							
<b>Signatures (required)</b>											
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					
<b>Agent Information</b>											
Name of Agent (print)			Agent Tax ID Number			Signature of Agent				Today's Date	
Phil Randazzo			FFNJPLJNVY								
<b>FOR ANTHEM USE ONLY</b>											
Group Number		Certificate Number			Effective Date		Area	By		Date	

Once completed, fax both sides of this form to Anthem Individual Membership at (303) 764-7282. Or 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 9051, Oxnard, CA 93031-9051.

It is unlawful to knowingly provide false, incomplete or misleading facts to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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# 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:**

- Credit/Debit Card     
  Paper Check\*     
  Electronic Check

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

- Monthly Credit/Debit Card *(complete Section below)*     
  Monthly Paper Billing     
  Quarterly Paper Billing—submit the three-month premium  
 Monthly Checking Account Automatic Premium Payment *(complete Section below)*     
  Bi-monthly Paper Billing

**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:

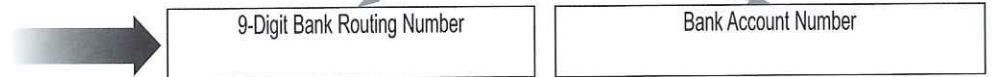
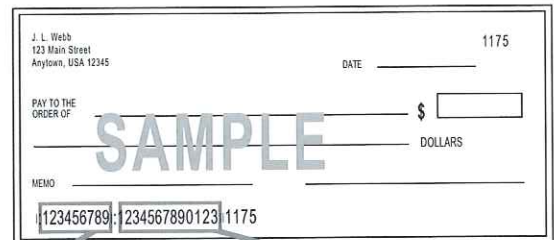
Authorized Signature <i>(as it appears on the credit card)</i>	Cardholder Name <i>(as it appears on the credit card)</i> PRINT	Date
X		

**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 <i>(as it appears in the financial institution's records)</i>	Account Holder Name 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.