

Anthem Blue PPO Dental Plan for Individual and Families

Anthem Blue Cross and Blue Shield now offers an affordable plan that provides coverage for regular dental care. With our Anthem Blue PPO Dental Plan, members have:

- Access to quality dental care at discounted rates.
- A wide range of dental services to meet their needs.
- No waiting period for preventive and diagnostic care.
- The freedom to choose any dentist.
- A yearly \$50 deductible per person with a maximum of three deductibles per family.

Additional Savings with In-network Dentists

Choosing an in-network dentist means receiving care at our negotiated discounted rates. Members may choose from a network of nearly 400 dental providers in Nevada. The plan still provides benefits if members choose an out-of-network dentist, but their out-of-pocket expenses may be higher. Members are responsible for any charges their out-of-network dentists bill that exceed the stated benefit amount.

Members in counties with limited network access may visit in-network dentists outside their local area and still receive coverage at the in-network negotiated rates. Benefits are still available for out-of-network dentists, as specified by the plan.

Eligibility

Individuals and their dependents must be Nevada residents. Eligible dependents include:

- Lawful spouses, 64 1/2 years old or younger.
- Any unmarried child or stepchild under age 19, of the member or the member's enrolled spouse.
- Any unmarried child or stepchild, who is a full-time student (at least 12 units per semester), under age 24.

Dental Benefit Schedules

These dental benefit schedules show a brief overview of benefits available to members. Anthem Blue Cross and Blue Shield pays either the specified amount or the actual amount charged by the provider, whichever is lower. The member is responsible for any charges exceeding the stated benefit amount.

Preventive and Diagnostic Care¹ Coverage begins on the policy effective date.		
Procedure	Anthem Pays	
	In-network Dentist	Out-of-network Dentist
Periodic oral exam, limited to 2 per member per year	100%	\$15
Bitewing X-rays (1 film ²)	100%	\$9
Bitewing X-rays (2 films ²)	100%	\$14
Single (periapical) X-rays (first film ²)	100%	\$9
Single X-rays (additional films ²)	100%	\$9
Bitewing X-rays (4 films ²)	100%	\$21
Full mouth X-rays, limited to 1 set every 3 years ²	100%	\$38
Routine cleaning, limited to 2 per adult per year ³	100%	\$40
Routine cleaning, limited to 2 per child per year ⁴	100%	\$26
Cleaning with fluoride, limited to 2 per child per year ⁴	100%	\$36
Topical fluoride only, limited to 2 per child per year ⁴	100%	\$12

Basic Dental Care¹ Coverage begins after the plan has been in effect for six continuous months.	
Procedure	Anthem Pays
	In-network and Out-of-network Dentists
Filling (1 surface/2 surfaces/3 surfaces/4 or more surfaces)	\$42/\$54/\$65/\$78
Extraction (erupted tooth or root)	\$39
Surgical removal of erupted tooth	\$72
Removal of impacted tooth (soft tissue/partial bony/complete bony)	\$100/\$120/\$150

Major Dental Care¹ Coverage begins after the plan has been in effect for 12 continuous months.	
Procedure	Anthem Pays
	In-network and Out-of-network Dentists
Scaling/root planing per quadrant	\$43
Gingivectomy (1 to 3 teeth per quadrant/4 or more contiguous teeth per quadrant)	\$30/\$97
Root canal (1 canal/2 canals/3 canals)	\$127/\$155/\$205
Crown (porcelain fused to high noble metal)	\$225
Stainless steel crown	\$55
Pontic (porcelain fused to high noble metal)	\$225
Partial/complete denture (upper or lower)	\$275/\$300
Denture relines (chairside/lab)	\$55/\$80

¹All dental benefits are limited to a maximum payment of \$1,000 for expenses incurred by each enrolled member during a calendar year.

²Total benefit for single and bitewing X-rays, not to exceed the cost of full mouth X-rays (\$38).

³Adult: Any person or dependent 19 years of age or older covered by the Anthem Blue PPO Dental Plan.

⁴Child: Any person or dependent 18 years of age or younger covered by the Anthem Blue PPO Dental Plan.

These schedules only provide a brief description of certain features of the plan. This is not the insurance contract and only the actual policy provisions will apply. The policy sets forth in more detail the benefits, limitations and exclusions. If there are any conflicts between the terms of the policy and the information in this brochure, the terms of the policy will prevail.

Dental Plan Limitations and Exclusions

The primary limitations and exclusions for the Anthem Blue PPO Dental Plan described in this brochure are listed below. This listing is an overview only. A more detailed list of the plan's limitations and exclusions can be found in the policy.

Limitations

The following primary limitations apply to the **Anthem Blue PPO Dental Plan**:

Prosthodontics: Replacement of a fixed or removable prosthesis if such replacement occurs within five years of the original placement, unless the denture is a stayplate used during the healing period for recently extracted anterior teeth.

Adjustment, repairs or relines to a prosthesis, except following six months after the initial placement and if the prosthesis was paid for under this plan.

Fixed bridges, removable cast partials and/or cast crown with or without veneers for patients under 16 years of age.

Replacement of crowns and cast restorations, including porcelain crowns, if such replacement occurs within five years of the original placement.

Prosthodontics and Periodontics: Services for fixed or removable prosthodontics within the first 12 months of the member's effective date.

Services for periodontics within the first 12 months of the member's effective date.

Diagnostic: Oral examinations exceeding two visits per member per year.

More than one set of full-mouth X-rays or its equivalent per member in a three-year period.

Preventive: Prophylaxis treatments exceeding two treatments per member per year.

Fluoride applications for patients over 18 years of age or applications exceeding two visits per year.

Exclusions

The **Anthem Blue PPO Dental Plan** does not provide benefits for:

- Any amounts exceeding the maximum amount stated in the yearly maximum benefit section of the policy or listed in the benefit schedule.
- Services or supplies Anthem Blue Cross and Blue Shield considers to be not medically necessary or experimental or investigational.
- Services received before the coverage effective date or after coverage ends.
- Services for which the member wouldn't be charged if the member didn't have insurance coverage or services for which the member is not legally obligated to pay.
- Any condition for which benefits could be recovered either by adjudication, settlement or otherwise under any workers' compensation, employer's liability or occupational disease law, even if the member doesn't claim those benefits.
- Disease contracted or injuries sustained as a result of declared or undeclared war and/or conditions caused by the inadvertent release of nuclear energy when government funds are available for treatment of illness or injury arising from such release of nuclear energy.
- Any services provided by a local, state, county or federal government agency, including any foreign government.
- Professional services received from a person who lives in the member's home or who is related to the member by blood, marriage or adoption.
- Any services performed for cosmetic purposes, unless they are for the correction of functional disorders or as a result of an accidental injury occurring while the member was covered under this policy.
- Charges for treatment by a person other than a licensed dentist or physician, except charges for dental prophylaxis performed by a licensed dental hygienist, under the supervision and direction of a dentist.
- Replacement of an existing prosthesis that has been lost, stolen, or which, in the opinion of a dentist, is or can be made satisfactory.
- Orthodontic services, braces, appliances and all related services.
- Diagnosis or treatment of the joint of the jaw and/or occlusion services, supplies or appliances provided in connection with:
 - Any treatment to alter, correct, fix, improve, remove, replace, reposition, restore or otherwise treat the joint of the jaw (temporomandibular joint).
 - Any treatment, including crowns, caps and/or bridges to change the way the upper and lower teeth meet (occlusion);
 - Treatment to change vertical dimension (the space between the upper and lower jaw).
- Procedures requiring appliances or restorations (other than those for replacement of structure loss from caries) that are necessary to alter, restore or maintain occlusions.
- Correction of congenital or developmental malformation.
- If a member transfers from the care of one dentist to that of another dentist during the course of treatment or if more than one dentist provides services for one dental procedure, Anthem Blue Cross and Blue Shield will only be responsible for the amount it would have been responsible for if one dentist provided the services.
- Prescribed drugs, premedication or analgesia.
- Oral hygiene instruction.
- Services for treatment of malignancies.
- All hospital costs and any additional fees charged by the dentist for hospital treatment.
- Implants (materials implanted into or on bone or soft tissue) or the removal of implants.
- Replacement of teeth missing before the coverage effective date.

Dental PPO Plan Monthly Rates

One adult	\$27.00
Two adults	\$54.50
Adult with 1 child	\$42.00
Adult with 2 children	\$56.50
Adult with 3+ children	\$79.00
Family (1 child)	\$69.00
Family (2 children)	\$84.00
Family (3+ children)	\$106.00
One child	\$15.00
Two children	\$29.50
Three+ children	\$51.50



ATTACH CHECK HERE

Anthem Blue Individual PPO Dental Plan Enrollment Application

Once completed, fax both sides of this form to Anthem Individual Membership at 303-764-7282.

If Anthem approves my application please assign an effective date of the

- 1st of the month following approval
- _____ (mm/dd/yy)

If you are an Anthem subscriber, please enter your current Anthem group number and certificate number.

GROUP NO.

CERTIFICATE NO.

Applicant Information – Applicant must complete this section.

Please print

Last Name		First Name		MI	Social Security No.	
Home Phone No. ()		Business Phone No. ()		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	
Home Address (Must be complete. P.O. Box not acceptable.)				Billing Address (If different or P.O. Box)		
City	State	Zip Code	City	State	ZIP Code	

Spouse to be Insured – Signature required below.

Last Name of Spouse	First Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (Mo/Day/Yr)	Social Security No.
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Children to be Insured

	NAME (First and Last Name)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE			SOCIAL SECURITY NO.
			MO	DAY	YR	
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				

Signatures (Required)

If the family member is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. If the responsible adult is not the natural parent, please submit court papers, authorizing guardianship. I understand that coverage is subject to all conditions and provisions specified in the Policy. I understand that receipt of money with this application does not create Anthem coverage. Coverage will come into effect only on approval by Anthem.

Signature of Applicant / Parent or Legal Guardian X	Today's Date	Signature of Applicant's Spouse X	Today's Date
Signature of Applicant / Parent or Legal Guardian X	Today's Date	Signature of Applicant's Spouse X	Today's Date

Agent Information

Name of Agent (Print) PAUL BAICHK	Agent Tax ID Number 880320333	Check One <input checked="" type="checkbox"/> EIN <input type="checkbox"/> SS #	Signature of Agent <i>[Signature]</i>	Today's Date
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FOR ANTHEM USE ONLY

Group No.	Certificate No.	Agent Tax I.D. No.	Effective Date	Area	By	Date
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An independent licensee of the Blue Cross and Blue Shield Association. Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. ® Registered marks Blue Cross and Blue Shield Association.

Select Billing Type

Monthly Paper Billing Quarterly Paper Billing Monthly Electronic Funds Transfer (EFT)

Please choose the draft date on which you would like your premium debited from your account and complete the Monthly Bank Authorization below:

1st 8th 15th 22nd of the month

Monthly Bank Draft Authorization

INSTRUCTIONS:

1. Complete this section.
2. Attach a blank check marked "VOID" to this form (Deposit slips or temporary checks are not acceptable).
3. Submit a check for one-month's premium made out to Anthem Blue Cross and Blue Shield. If the account listed below is a joint account, both account holders' signatures are required.

All funds are drawn on the first of each month. Premiums may be prorated in order to adjust the initial paid-to-date or in the event of membership changes.

OPTIONAL MONTHLY BANK DRAFT AUTHORIZATION. 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 Life & Health Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check drawn on you and signed personally by me. I authorize Anthem Life & Health Insurance Company to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Life & Health Insurance Company premium. This authority is to remain in effect until revoked by me in writing and until you actually receive such 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 through such dishonor results in forfeiture of insurance.

NOTE TO APPLICANT: Should your withdrawal not be honored by your bank, you will automatically be removed from monthly checking account deduction and be billed quarterly. After 12 months, you may re-apply for the monthly checking account deduction option.

You will incur a service charge for any withdrawal not honored. Anthem must be notified of any changes to your bank account.

Applicant's Name _____

Applicant's Social Security No. _____

Name on Checking Account (If different from above) _____

Checking Account No. _____

Name of Bank _____

Routing No. _____

X Authorized Signature (As it appears in the financial institution's records) _____

Date _____

Initial Premium Payment by Electronic Check _____

Select one: 1 month 3 months

Check No. _____ Initial Premium Amount Electronic Check
\$ _____

Bank/Credit Union Routing No. _____

Checking Account No. (as it appears on your check) _____

Name on Account _____

Initial Premium Payment by Credit Card

New members only. Not available to make a coverage change.

Select one: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months	Initial Premium Amount Credit Card: \$ _____	Credit Card <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard
Credit Card No. _____	Expiration Date _____	
Cardholder's Name _____	Cardholder's ZIP Code _____	
Authorized Signature (as it appears on the credit card) X _____	Today's Date _____	