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Anthem Blue PPO Dental Plan

For Individuals and Families

Nevada

Anthem

Freedom to choose any dentist

Access to quality care at discounted fees

Wide range of dental services

Preventive and diagnostic coverage begins on your policy effective date

PPO Dental Plan Coverage for Individuals and Families

Oral health affects both physical and mental wellness – and therefore quality of life. That's why Anthem Blue Cross and Blue Shield offers the Anthem Blue PPO Dental Plan for individuals and families.

We designed our PPO dental plan with two goals in mind: to promote good dental hygiene and preventive care, important elements in a total health care package, and to provide you with the dental benefits you need in a convenient, cost-conscious manner.

The plan features preventive and diagnostic care, basic dental care, and major dental care. Coverage includes a wide range of dental services, such as routine check-ups, cleanings, fillings, crowns and dental surgery, and features a benefit schedule that can help you offset the high cost of major dental care. And, you may see any dentist you choose, although your out-of-pocket costs will be lower if you select dental providers in our network.

Please read this brochure for information about how our Anthem Blue PPO Dental 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 care at Anthem Blue Cross and Blue Shield's negotiated discounted rates. If you choose an out-of-network provider, we still provide benefits, but 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.

We let you know up front in flat dollar amounts 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 the specific procedure(s) listed.

If your current dentist isn't in our network and you want him/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 Dentist	
If the billed amount is:	$850
And Anthem's negotiated rate is:	$430
Anthem will pay the amount specified in the benefit schedule:	$225*
Therefore, you pay the difference between the negotiated amount and the scheduled benefit:	$205

Out-of-network Dentist	
If the billed amount is:	$850
Anthem will pay the amount specified in the benefit schedule:	$225*
Therefore, you pay the difference between the billed amount and the scheduled benefit:	$625

*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 Las Vegas, Nevada, area (ZIP code 89101) for American Dental Association procedure code D2750. The information in this example is from Anthem Blue Cross and Blue Shield's 2003 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 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

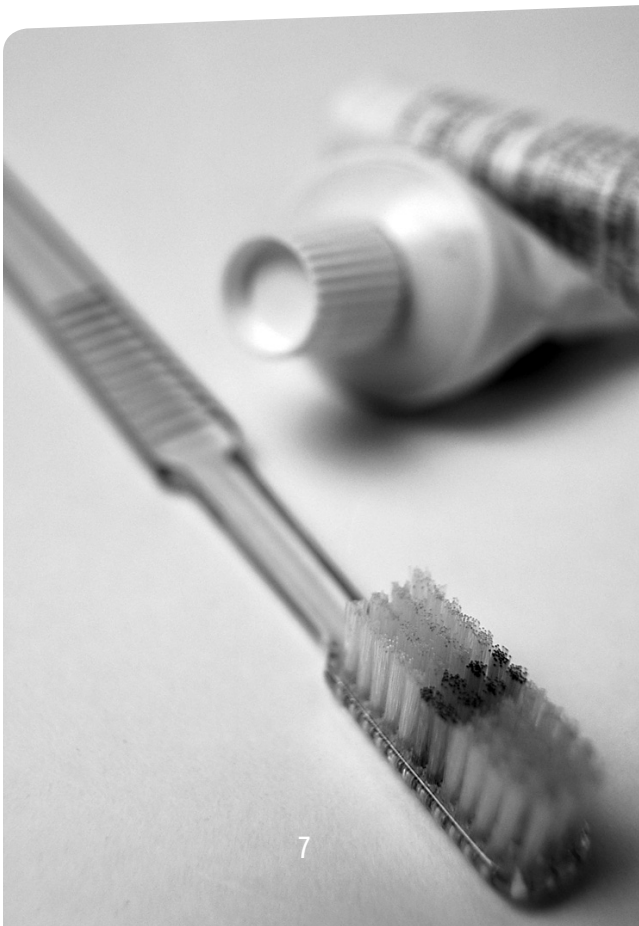
Coverage for preventive and diagnostic care begins on your plan effective date. Coverage for basic care begins after six continuous months of coverage, and coverage for major care begins after 12 continuous months of coverage.

Customer Service

Our professional customer service representatives are available to help you and answer questions you have 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.



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 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).

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 1 per year)	100%	$40.00
Routine cleaning (limited to 2 per child 2 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

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

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

Rates are effective as of November 1, 2005, and are subject to change without notice.

Basic Dental Care

- Coverage begins after the plan has been in effect 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.
- The benefit schedule is the same for in-network and out-of-network dentists, but your out-of-pocket costs may be higher if you choose an out-of-network dentist.

Procedure	Plan Pays
Filling (1 surface)	$42.00
Filling (2 surfaces)	$54.00
Filling (3 surfaces)	$65.00
Filling (4 or more surfaces)	$78.00
Extraction (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 effective as of November 1, 2005, and are subject to change without notice.

Major Dental Care

- Coverage begins after the plan has been in effect 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.
- The benefit schedule is the same for in-network and out-of-network dentists, but your out-of-pocket costs may be higher if you choose an out-of-network dentist.

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 (porcelain fused to high noble metal)	$225.00
Stainless steel crown	$55.00
Pontic (porcelain fused to high noble metal)	$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 effective as of November 1, 2005, and are subject to change without notice.

Eligibility and Enrollment

To be eligible for enrollment, you must be:

- A resident of the state of Nevada 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.
- Age 64 1/2 or younger.
- The applicant's lawful spouse, age 64 1/2 or younger.
- The applicant's unmarried child up to age 19.
- The applicant's unmarried child and a full-time student (at least 12 units per semester), under age 24.
- The applicant's unmarried stepchild and reside with the applicant up to age 19 or, if a full-time student (at least 12 units per semester), under age 24.
- Not enrolled under any other Anthem Blue Cross and Blue Shield individual or group dental plan.

Plan Effective Date

Your plan effective date will be printed on the dental plan card you'll receive once your enrollment is approved. Your coverage will stay in effect on a three-month basis if you choose quarterly coverage or on a monthly basis if you choose automatic deduction from your checking account for your premium payment.

Anthem Blue PPO Dental Plan Rates Effective November 1, 2005.	
One adult	$27.00
Two adults	$54.50
Adult with one child	$42.00
Adult with two children	$56.50
Adult with three or more children	$79.00
Family (one child)	$69.00
Family (two children)	$84.00
Family (three or more children)	$106.00
One child	$15.00
Two children	$29.50
Three or more children	$51.50

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

Terms of Coverage

Coverage under the Anthem Blue PPO Dental 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 overage dependents, Anthem Blue Cross and Blue Shield will offer you a similar plan.) Anthem may change the premiums of this plan after providing you with 60 days' 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

Anthem Blue Cross and Blue Shield's PPO Dental Plan for individuals and families does not provide benefits for:

- Unlisted services: services not listed in the plan's benefit schedule.
- Excess amounts: any amounts exceeding the maximum amount stated in the yearly maximum benefit section of the policy or listed in the benefit schedule.
- Experimental or investigational procedures: services or supplies that Anthem considers experimental or investigational.
- Expenses before coverage begins: services received before the coverage effective date.
- Expenses after the end of coverage: services received after coverage ends.
- Services the member isn't legally obligated to pay for:services for which the member wouldn't be charged if the member didn't have insurance coverage.
- Conditions related to workers' compensation: 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.
- Conditions related to war: disease contracted, or injuries sustained, as a result of war, declared or undeclared, and 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.
- Government services: any services provided by a local, state, county or federal government agency, including any foreign government.
- Services from relatives: 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.
- Cosmetic dentistry: any services performed for cosmetic purposes, unless they are performed to correct functional disorders or as a result of an accidental injury that occurred while the member was covered under the plan.
- Charges for treatment provided 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 or stolen or which, in the opinion of the dentist, is or can be made satisfactory.
- Replacement of a fixed or removable prosthesis if such replacement occurs within five years of the original placement, unless the prosthesis is a stayplate used during the healing period for recently extracted anterior teeth.
- Orthodontic services, braces, appliances and all related services.
- Diagnosis or treatment of the joint of the jaw and/or occlusion (the way upper and lower teeth meet), services, supplies, or appliances provided in connection with: (a) any treatment to alter, correct, fix, improve, remove, replace, reposition, restore or otherwise treat the joint of the jaw (temporomandibular joint) or associated musculature, nerves and other tissues for any reason, or by any means; or (b) any treatment, including crowns, caps and/or bridges to change the way the upper and lower teeth meet (occlusion); or (c) treatment to change the vertical dimension (the space between the upper and lower jaw) for any reason or by any means, including the restoration of the vertical dimension because teeth have worn down.
- Procedures requiring appliances or restorations (other than those for replacement of structure loss from caries) that are necessary to alter, restore or maintain occlusions. These include, but are not limited to: (a) changing the vertical dimension; (b) replacing or stabilizing lost tooth structure by attrition, abrasion or erosion; (c) realignment of teeth; (d) gnathological recording; (e) occlusal equilibration; and (f) periodontal splinting.
- Oral examinations exceeding two visits per member per year.
- Prophylaxis treatments exceeding two treatments per member per year.
- Fluoride applications for members over 18 years of age and fluoride applications exceeding two treatments per insured child per year.
- More than one set of full-mouth X-rays or its equivalent per member in a three-year period.

- Correction of congenital or developmental malformation for a member, including, but not limited to, cleft palate, maxillary or mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).
- Adjustments, repairs or relines to a prosthesis, except after six months from the initial placement and if the prosthesis was paid for under this plan.
- Fixed bridges, removable cast partials and/or cast crowns 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.
- Transfer of care: 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.
- Malignancies and neoplasms: services for treatment of malignancies and neoplasms.
- 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. However, if implants are provided in association with a covered prosthetic appliance, Anthem Blue Cross and Blue Shield will pay the benefit amount for a standard complete or partial denture or a bridge toward the cost of implants and the prosthetic appliance.
- Services or supplies that are not medically necessary.
- Replacement of teeth missing before the coverage effective date.
- Services for periodontics and fixed or removable prosthodontics within the first 12 months of the member's effective date.

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.
- 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:

- See the instructions on the attached enrollment application.

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 9051
  Oxnard, CA 93031-9051

Anthem

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)

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

Last Name	First Name

Home Phone Number	Business Phone Number
( )	( )

Home Address (Must be complete. A P.O. box is not acceptable.)

City	State	ZIP Code

Spouse to be Insured *Signature required below*

Last Name of Spouse	First Name of Spouse	Ge
		☐

Children to be Insured

	NAME (first and last name)	GE
1.		☐
2.		☐
3.		☐
4.		☐

Signatures (required)

If any family member listed above is a minor, I (Applicant) accept full legal and fir
(If the responsible adult is not the natural parent but is the legal guardian, or i
papers.) I (Applicant) understand that coverage is subject to all conditions and
payment with this application does not create Anthem Blue Cross and Blue Sh

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

Agent Information

Name of Agent (print)	Agent Tax ID Number

FOR ANTHE

Group Number	Certificate Number	Effective Date

Once completed, fax both sides of this form to Anthem Individua
application to Anthem Blue Cross and Blue Shield with a check f
Anthem Blue Cross and Blue Shield, Individual Product Administ

It is unlawful to knowingly provide false, incomplete or misleading facts to an insurance company for the purpose of defrauding or attempting
an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the pur
shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Anthem Blue Individual PPO Dental Plan Enrollment Application

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

	MI	Social Security Number	
Gender ☐ M ☐ F	Marital Status ☐ Single ☐ Married	Age	Date of Birth (mm/dd/yy)

Billing Address (if P.O. box or different from home address)

City	State	ZIP Code

ender M ☐ F	Date of Birth (mm/dd/yy)	Social Security Number

ENDER	DATE OF BIRTH (mm/dd/yy)	SOCIAL SECURITY NUMBER
M ☐ F		
M ☐ F		
M ☐ F		
M ☐ F		

nancial responsibility for the coverage and information provided on this application. s under court order to provide coverage, please submit substantiating court provisions specified in the policy. I (Applicant) understand that receipt of ield coverage. Coverage will be effective only upon approval by Anthem.

Signature of Applicant's Spouse	Today's Date
X	
Signature of Applicant's Dependent Age 18 or Over	Today's Date
X	

	Signature of Agent	Today's Date

EM USE ONLY

Area	By	Date

al Membership at (303) 764-7282. Or mail your completed for the first month's premium to your agent or to: ration, P.O. Box 9051, Oxnard, CA 93031-9051.

g to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of pose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds

Payment Options

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

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

Complete instructions are provided on the *Payment Options* form.

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

- Monthly credit/debit card
- Monthly checking account automatic premium payment
- Monthly paper billing
- 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.

Payment Options

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* ☐ Elec

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

☐ Monthly Credit/Debit Card *(complete Section below)*

☐ Monthly Checking Account Automatic Premium Payment *(complete Section below)*

Monthly Credit/Debit Card

As a convenience to me, I request and authorize you to charge my card for monthly recurring p
change(s) during underwriting, and/or subsequent payment amounts may vary as a result of ch
my residence. The amount may also change as outlined in my policy. This authority is to remain
protected in honoring any such card payments. I further agree that if any such card payment be
under no liability whatsoever, including any fees imposed by my bank, should my card be reject

☐Visa ☐ MasterCard [☐Discover]

Card Number:

(13 or 16 digits)

Authorized Signature *(as it appears on the credit card)*	Cardholde
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. 9

As a convenience to me, I request and authorize you to pay and charge to my account checks
there are sufficient collected funds in said account to pay the same upon presentation. I unders
subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as
rights in respect to each such debit shall be the same as if it were a check signed personally by
debits) from my account with the financial institution indicated for payment of my Anthem Blue C
ing you a 30-day written notice. I agree that you shall be fully protected in honoring any such de
intentionally or inadvertently, you shall be under no liability whatsoever even though such disho
you will automatically be removed from monthly checking account automatic premium payment

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

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

Electronic Check

In lieu of sending a paper check, we can submit this same information electronically. You wi
check you are using. Please void this check to prevent future use.

Account Holder Name PRINT	Bank Routing Number

** By sending your paper check, you authorize us to convert your check to an electronic fund trans
on the check. If you do not qualify for coverage, your check will not be submitted for a funds tra*

Applicant Social Security or ID Number

tronic Check

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

☐ Bi-monthly Paper Billing

remiums on each due date. I understand that the initial payment amount may vary as a result of ange(s) I make once enrolled, such as, but not limited to, adding and deleting dependents or moving n in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully e dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be ted even though such dishonor results in forfeiture of coverage.

Expiration Date: ___/___

Cardholder ZIP Code: _____–____

er Name *(as it appears on the credit card)* PRINT	Date

-Digit Bank Routing Number

Bank Account Number

drawn on that account by and payable to the order of Anthem Blue Cross and Blue Shield, provided tand that the initial payment amount may vary as a result of change(s) during underwriting, and/or , but not limited to, adding and deleting dependents or moving my residence. I agree that your me. I authorize Anthem Blue Cross and Blue Shield to initiate debits (and/or corrections to previous Cross and Blue Shield premiums. This authority is to remain in effect until revoked by me by providebit. I further agree that if any such debit be dishonored, whether with or without cause and whether nor results in forfeiture of insurance. **NOTE:** Should your withdrawal not be honored by your bank, and will be billed monthly.

Holder Name PRINT	Date

ll need to complete the information below. We require an exact amount and check number of the

	Account Number	Amount	Check Number
		$	

sfer. If you are approved for coverage, your bank account will be debited for the amount indicated nsfer. Please be aware that your check will not be returned to you.

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

Applicants who are approved for enrollment will receive Anthem Blue Cross and Blue Shield's policy for the Nevada PPO Dental Plan for individuals and families. Please review it carefully, as it contains details about your benefits, coverage, exclusions and limitations. This brochure only provides highlights of Anthem Blue Cross and Blue Shield's Nevada PPO Dental Plan for individuals and families. In the event of a conflict between the information in this brochure and the terms of the plan's policy, the terms and conditions of the policy will prevail.

MNVBR2793A (8/08)