The Local Choice

The Local Choice Health Benefits

Dental/Vision Benefits Insert

This insert, along with The Local Choice Medicare-Coordinating Plans Member Handbook, constitutes a complete description of benefits, exclusions and limitations under the plan for enrollees who are eligible for and have elected these benefits.

January 2011

The Local Choice Health Benefits Program

Administered by the Department of Human Resource Management
Commonwealth of Virginia

T20746 (01/11)

IMPORTANT NOTICE

This insert describes the dental and vision services that are available for reimbursement under The Local Choice Health Benefits Program if you are enrolled in a Plan that includes these benefits. The plans that include these benefits are Advantage 65 with Dental/Vision and Medicare Complementary.

Throughout this insert there are words which begin with capital letters. In most cases, these are defined terms. See the "Definitions" sections of your Medicare-Coordinating Plans Member Handbook and this insert for the meaning of these words.

Your Dental/Vision coverage is limited to the services specifically described in this insert as eligible for reimbursement. There are specific Exclusions for which the program will never pay. Even more important, payment for covered services is almost always conditional. That is, payment may be denied for covered services you receive without observing all of the conditions and limits under which they are covered.

Your benefits are governed strictly by the written provisions of this coverage. Only those dental and vision services specifically named or described in this insert are covered. You are responsible for knowing what is covered and the limits and conditions of coverage. The terms and conditions of your coverage can be changed if proper notice is given to you.

There are some rules and information that apply to all benefits (medical and dental/vision based on your own coverage), including applicable "General Rules Governing Benefits", "Exclusions", "Basic Plan Provisions", "Definitions" and "Eligibility" that are included in your Local Choice Health Benefits Program Medicare-Coordinating Plans Member Handbook. In addition, any rules or information that applies specifically to Dental/Vision benefits will be included in this insert.

USING YOUR DENTAL/VISION BENEFITS TO THE BEST ADVANTAGE

Use of Participating Providers in the claims administrators' networks will ensure that you are not charged above the network Allowable Charge level. If you use a Non-Participating Provider, you will have to pay any charges over the Allowable Charge level or a higher co-payment or coinsurance as described in this insert, and you may have to file your own claim.

Since Medicare does not cover routine dental and vision services, the Dental/Vision coverage under your Plan does not coordinate with Medicare. However, when it is requested, you must report any other coverage in which you are enrolled so that your benefits may be coordinated as described in the "Coordination of Benefits" section of "General Rules Governing Benefits" in your Medicare-Coordinating Plans Member Handbook.

SUMMARY OF BENEFITS

	Covered Services	you Pay
Dental	Plan pays up to $1,500 per participant per Calendar Year: • Diagnostic and Preventive Care • Basic Dental Care • Major Dental Care	 $0 of AC* 20% of AC* 95% of AC*
Vision	Plan pays for the following routine vision benefits once every 24 months	
(in-network provider)**	Routine eye exam (one)	$20 copayment
	Eyeglass frames (one pair)	Charges over $100 allowance (20% off remaining balance)
	Eyeglass Lenses	
	• Standard plastic single vision lenses (one pair)	$20 copayment
	• Standard plastic bifocal lenses (one pair)	$20 copayment
	• Standard plastic trifocal lenses (one pair)	$20 copayment
	• Standard progressive lenses (one pair)	$85 copayment
	Contact lenses	
	• Elective conventional lenses	Charges over the $100 allowance (15% off remaining balance)
	• Elective disposable lenses	Charges over the $100 allowance (no additional discount)
	• Non-elective contact lenses	Charges over the $250 allowance (no additional discount)

* Allowable Charge

** Out-of-Network vision benefits are outlined in the Blue View Vision section of this insert.

WHO TO CONTACT FOR ASSISTANCE

Dental Plan Claims Administration

Delta Dental of Virginia

Customer Service	888-335-8296
Web Address	**www.deltadentalva.com** Click on “The Commonwealth of Virginia Retiree Health Benefits Program”
Hours of Operation	Monday through Thursday, 8:15 a.m. to 6:00 p.m. Friday, 8:15 a.m. to 4:45 p.m.
Mailing Address	4818 Starkey Road Roanoke, VA 24018

Vision Plan Claims Administration

Anthem Blue Cross and Blue Shield – Blue View Vision

Member Services	800-552-2682
Web Address	**www.anthem.com/tlc** Select "Medicare Retirees" under Tools & Information.
Mailing Address	Anthem Blue Cross and Blue Shield Member Services P. O. Box 27401 Richmond, VA 23279
Hours of Operation	Monday through Friday, 8:00 a.m. to 6:00 p.m. Saturday, 9:00 a.m. to 1:00 p.m.
ID Card Order Line	866-587-6713

Eligibility and Enrollment

The Local Choice Health Benefits Program
Commonwealth of Virginia
Department of Human Resource Management
101 North 14th Street - 13th Floor
Richmond, VA 23219
(804) 786-6460
www.thelocalchoice.virginia.gov

Program Administration

Department of Human Resource Management
The Local Choice Health Benefits Program

Web address	**www.thelocalchoice.virginia.gov**
E-mail	**tlc@dhrm.virginia.gov**

GENERAL RULES GOVERNING BENEFITS

All applicable “General Rules Governing Benefits” listed in the Medicare-Coordinating Plans Member Handbook also apply to the Dental/Vision benefits described in this insert.

DENTAL BENEFITS

Services Which Are Eligible for Reimbursement

Diagnostic and Preventive Care

This plan provides coverage for you to see your dentist twice a year for a checkup. This allows your dentist to identify any possible problems and try to prevent cavities and serious dental problems. The following services are generally covered, but in some specific situations, certain exclusions and limitations apply. See "Special Limits" in this section, the "Exclusions" section of this booklet, and your Medicare-Coordinating Plans Member Handbook for more information.

- Two routine oral evaluations per Plan Year;
- Two dental prophylaxes (cleanings) per Plan Year, including scaling and polishing of teeth;
- Space maintainers used to keep teeth from moving into space left when deciduous teeth are pulled;
- Two tests to see if a tooth is still alive (pulp vitality tests) every 12 months (the 12-month count starts the month in which you receive the pulp vitality test);
- Care for a toothache (palliative emergency care);
- Two sets of bitewing x-rays (two or more films) per Plan Year (vertical bitewings are considered a full mouth series and are allowed once every 36 months);
- One complete full-mouth x-ray series (vertical bitewings are considered a full-mouth series), or a panorex every 36 months (the 36-month count starts the month in which you receive the x-ray series or panorex);
- Two topical fluoride applications per Plan Year only to Covered Persons under age 19;
- Dental pit/fissure sealants to the unrestored occlusal surface of the first and second permanent molars (limited to one application per tooth). Dental pit/fissure sealants are available only to Covered Persons under age 19;
- Occlusal adjustments, bite planes or splints for temporomandibular joint disorders;
- Occlusal night guards for demonstrated tooth wear due to bruxism; or occlusal orthotic device for treatment of temporomandibular joint dysfunction (TMJ). Services are limited to once every five-year period.

Basic Dental Care

After your dentist has examined your teeth, you may need additional dental work. Your plan includes coverage for the following:

- Fillings (amalgam or tooth-colored materials);
- Pin retention;
- Simple extractions of natural teeth and surgical extractions of fully erupted teeth;
- Root canal therapy (endodontics)—repeat treatment is covered only after two years from initial treatment;
- Care for abscesses in the mouth (excision and drainage);
- Repair of broken removable dentures—cost limited to one half of a new denture or prosthesis;
- Surgical preparation of ridges for dentures;
- Re-cementing existing crowns, inlays and bridges (one every 12 months);
- Removing infected parts of the gum and replacing them with healthy tissue (gingivectomy and gingivoplasty);
- Scaling and root planing of the gum—two year limitation);
- Stainless steel crowns for primary teeth only;
- Sedative fillings;
- Therapeutic pulpotomy for primary “baby” teeth only;
- Periodontal evaluation (not in addition to periodic evaluations);
- An operation to remove diseased portions of bone around the teeth (osseous surgery);
- Soft tissue grafts;
- Bone graft (only around natural teeth);
- Guided tissue regeneration;
- General anesthesia in connection with a covered surgical dental service is covered when three or more surgical extractions are performed. Not covered for deciduous teeth;
- Crown lengthening when bone is removed and at least six weeks are allowed for healing;
- Frenectomies;
- Hemisection and root amputations;
- Apicoectomies;
- Surgical periodontic services (soft tissue and bony surgery, including grafts)—three year limitation
- Periodontal maintenance limited to two per Plan Year – history of definitive periodontal therapy and continued maintenance therapy required; and
- Trips by the dentist to your home if you need any of the services you see listed here.

Major Dental Care

If preventive or basic dental care fails to save a tooth, major dental care is provided as follows:

- Inlays (limited to the benefit for a resin restoration unless part of partial or bridge abutment);
- Onlays (limited to the benefit for a metallic restoration);
- Crowns, crown repair, and post and core build-ups for crowns (once per tooth every five years);
- Labial veneers involving the incisal edge of anterior teeth, porcelain laminate (laboratory processed);
- Dental implants (once in a lifetime per site);
- Dentures (full or partial) once every five years, and denture adjustments and relining;
- Fixed bridges once every five years, and repair.

Healthy Smile, Healthy you Program

There is a growing connection between oral health and overall body health. With Delta Dental's Healthy Smile, Healthy you Program, participants who have been diagnosed with certain types of high-risk cardiac conditions, diabetes, or who are pregnant are eligible for one additional cleaning and exam (or periodontal maintenance procedure if there is a history of periodontal surgery) beyond your plan's ordinary limit per calendar year.

For more information, visit **www.deltadentalva.com**, or call Delta Dental Customer Service.

Conditions for Reimbursement

Should you decide to receive dental care from a dentist who is not a member of the Delta Dental Premier or PPO network, you will still receive benefits from your dental plan, but your share of the cost will likely be higher than if you received care from a network dentist.

- you may have to file any claims yourself.
- Payment will be made directly to you unless your dentist agrees to accept payment from Delta Dental.
- you must pay the applicable Coinsurance and the difference between the non-network dentists' charges and Delta Dental's payment for covered benefits.

Special Limits

1) Benefits are limited to $1,500 per participant per Calendar Year for all services. If you transfer to another Medicare-coordinating plan that includes these benefits, your total annual benefit will still be limited to $1,500.

2) If you transfer from the care of one dentist to another during a course of treatment, the Claims Administrator will only pay the amount it would pay to one dentist for the same treatment.

3) If more than one dentist renders services for one procedure, the Claims Administrator will only pay the amount it would pay to one dentist for the same treatment.

NOTE: If dental services for a single procedure or series of procedures cost more than $250, it is recommended that your dentist submit a predetermination plan to Delta Dental before services are provided. By submitting a predetermination plan, you and your dentist will be informed of: the total costs associated with the procedure(s); the exact amounts that will be covered by your health Plan; and the portion of the charges for which you will be responsible. A predetermination plan is not required by your health Plan, but it is recommended when extensive dental work is expected. A claim will not be denied for failure to obtain a predetermination plan.

Dental Plan Exclusions

The following services and/or supplies are excluded from coverage:

- Dental supplies;
- Brush biopsies of the oral cavity;
- Services rendered after the date of termination of the covered person's coverage. There is one exception. Covered prosthetic services which are prepped or ordered before the termination date are covered if completed within 30 days following the termination date;
- Gold foil restorations;
- Athletic mouth guards;
- Temporary dentures, crowns or duplicate dentures;
- Oral, inhalation or intravenous (IV) sedation;
- Bleaching of discolored teeth;
- Dental pit/fissure sealants on other than first and second permanent molars;
- Root canal therapy on other than permanent teeth;
- Pulp capping (direct or indirect);
- Upgrading of working dental appliances;
- Precision attachments for dental appliances;
- Tissue conditioning;
- Separate charges for infection control procedures and procedures to comply with OSHA requirements;
- Separate charges for routine irrigation or re-evaluation following periodontal therapy;
- Analgesics (nitrous oxide);
- General anesthesia except in conjunction with oral surgery, surgical periodontia, or surgical endodontia and then only when the underlying dental service is a covered benefit;
- Diagnostic photographs;
- Periodontal splinting and occlusal adjustments for periodontal purposes;
- Occlusal analysis;
- Controlled release of medicine to tooth crevicular tissues for periodontal purposes;
- Tooth desensitizing treatments;
- Care by more than one dentist when you transfer from one dentist to another during the course of treatment;
- Care by more than one dentist for one dental procedure, or by someone other than a dentist or qualified dental hygienist working under the supervision of a dentist;
- Preventive control programs, or oral hygiene instructions;
- Complimentary services or dental services for which the participant would not be obligated to pay in the absence of the coverage under your health Plan or any similar coverage;
- Dental services for lost, misplaced or stolen prosthetic devices including orthodontic retainers, space maintainers, bridges and dentures (among other devices);
- Services that Delta Dental determines are for the purpose of cosmetic surgery or dentistry for cosmetic purposes;
- Services that Delta Dental determines are for the purpose of correcting congenital malformations or replacing congenitally missing teeth;
- Dental services for increasing vertical dimension, restoring occlusion, correcting developmental malformations, or for aesthetic purposes;
- Services billed under multiple dental service procedure codes which Delta Dental, in its sole discretion, determines should have been billed under a single, more comprehensive dental service procedure code. Delta Dental's payment is based on the allowance for the more comprehensive code, not on the allowances for the underlying component codes;

- Services covered under medical benefits;
- Any services not listed as covered in this insert;
- Services determined by Delta Dental, in its sole discretion, to be not necessary or customary for the diagnosis or treatment of the condition. Delta Dental will take into account generally accepted dental practice standards in the area in which the dental service is provided. In addition, a covered person must have a valid need for each covered benefit. A valid need is determined in accordance with generally accepted standards of dentistry.

Reimbursement

The Claims Administrator pays the remaining Allowable Charge after your Coinsurance for covered dental services.

Coinsurance (the amount you pay)

Diagnostic and Preventive Care	0% of Allowable Charge
Basic Dental Care	20% of Allowable Charge
Major Dental Care	95% of Allowable Charge

VISION BENEFITS

Services Which Are Eligible for Reimbursement

1) Routine vision examination, once every 24 months

2) Frames and the following prescription lenses to correct refraction error, once every 24 months:

- Standard plastic single vision lenses, or
- Standard plastic bifocal lenses, or
- Standard plastic trifocal lenses, or
- Standard progressive lenses, or
- Conventional contact lenses

Conditions for Reimbursement

Vision services must be:

- Billed by a Provider in private practice.
- Rendered by a Provider licensed to do so
- Received from a Blue View Vision network Provider in order to receive in-network benefits.
- Services received out-of-network will be reimbursed according to the out-of-network allowance.

Special Limits

1) These benefits are available once every 24 months. The 24-month count starts the date you receive an eye exam or purchase eyewear.

2) Benefits will not be provided for more than the following in a 24-month period:

- One routine vision examination, and
- One pair of frames, or
- One pair of contact lenses or the designated allowance toward the cost of a supply of contact lenses

Vision Plan Exclusions

Your coverage does not include benefits for the following routine vision services. This list includes the majority of vision services not covered under your Plan, and is not a comprehensive list of all non-covered services.

1) Eye Surgery. Any medical or surgical treatment of the eyes and any diagnostic testing. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism, or contact lenses and eyeglasses required as a result of this surgery.
2) Benefits cannot be combined with any offer, coupon, or in-store advertisement.
3) Prescription sunglasses of any type; however, discounts are available for nonprescription sunglasses, tints or transition lenses.
4) Discounts are not available for certain brand-name frames in which the manufacturer imposes a no-discount policy.
5) Services required by your employer in connection with employment or benefits that would be covered under worker's compensation.
6) Safety glasses and accompanying frames.
7) Hospital Care - Inpatient or Outpatient hospital vision care.
8) Orthoptics or vision training and any associated supplemental testing.
9) Any non-prescription lenses, eyeglasses, contacts, Plano lenses or lenses that have no refractive power.
10) Any other vision services not specifically listed as covered in accordance with the member handbook insert.

Benefit/Reimbursement

Covered Service – In-Network:	**Your cost:**
Routine vision examination	$20 Copayment
Eyeglass frames	**Plan pays** $100 allowance; you pay the remaining balance with a 20% discount
Eyeglass lenses *(one of the following)*	
• Standard plastic single vision lenses (1 pair)	$20 Copayment
• Standard plastic bifocal lenses (1 pair)	$20 Copayment
• Standard plastic trifocal lenses (1 pair)	$20 Copayment
• Standard progressive lenses (1 pair)	$85 Copayment

Eyeglass lens upgrades (eyeglass lens copayment applies)

• UV coating	$15 copayment
• Tint (solid and gradient)	$15 copayment
• Standard scratch-resistance	$15 copayment
• Standard polycarbonate	$40 copayment
• Standard anti-reflective coating	$45 copayment
• Other add-ons and services	you pay the cost with a 20% discount

Contact lenses

You may choose to receive contact lenses instead of eyeglass lenses.

Elective Conventional lenses[1]	**Plan pays** $100 allowance; you pay the remaining balance with a 15% discount
• Elective Disposable lenses[1]	**Plan pays** $100 allowance; you pay the remaining cost
• Non-Elective Contact lenses[1]	**Plan pays** $250 allowance; you pay the remaining cost

Contact lens fitting and follow-up

A contact lens fitting, and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.

Standard contact fitting — you pay up to $55

A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement lenses.

Premium contact lens fitting — you pay the cost with a 10% discount

A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal lenses.

Additional Savings on Eyewear and Accessories

After you use your initial frame or contact lens benefit allowance, you can take advantage of discounts on additional prescription eyeglasses, conventional contact lenses, and eyewear accessories at Blue View Vision network Providers at any time. The 24-month restriction does not apply. Blue View Vision's Additional Savings Program is subject to change without notice.

Service:	Your Discount:
• Additional complete pair of eyeglasses (as many as you like)	40% off retail
• Conventional Contact Lenses (materials only)	15% off retail
• Additional Eyewear & Accessories (Includes eyeglass frames and eyeglass lenses purchased separately, some non-prescription sunglasses, eyeglass cases, lens cleaning supplies, contact lens solutions, etc.)	20% off retail

[1] Elective contact lenses are in lieu of eyeglass lenses. Non-elective lenses are covered when glasses are not an option for vision correction.

Out-of Network Benefits

you can choose to receive care outside of the Blue View Vision network. The following allowances apply to out-of-network coverage. you pay any cost above the allowance.

Service:	Out-of-Network Allowance:
• Routine eye exam	$40 allowance
• Eyeglass frames	$75 allowance
• Standard plastic single vision lenses (1 pair)	$50 allowance
• Standard plastic bifocal lenses (1 pair)	$75 allowance
• Standard plastic trifocal lenses (1 pair)	$100 allowance
• Elective conventional and disposable lenses[1]	$80 allowance
• Non-Elective Contact lenses[1]	$210 allowance
• Standard Progressive Lenses	Not Covered

You will need to pay for covered services and purchases at the time of your visit, and send an out-of-network claim form and itemized receipt to Blue View Vision for reimbursement. The claim form is available at **www.anthem.com/tlc**. Select "Medicare Retirees" under the Tools & Information.

[1] Elective contact lenses are in lieu of eyeglass lenses. Non-elective lenses are covered when glasses are not an option for vision correction.

Exclusions

In addition to the dental and vision exclusions listed in this insert, all applicable “Exclusions” listed in the Medicare-Coordinating Plans Member Handbook also apply to the Dental/Vision benefits described in this insert.

Basic Plan Provisions

All applicable “Basic Plan Provisions” listed in the Medicare-Coordinating Plans Member Handbook also apply to the dental and vision benefits described in this insert.

Definitions

All applicable “Definitions” listed in the Medicare-Coordinating Plans Member Handbook also apply to the Dental/Vision benefits described in this insert. The following definition differs under these Dental/Vision benefits described in this insert from the definition in the Member Handbook:

Participating and Non-Participating Providers
For this vision coverage, a Participating Provider is a Provider who is listed as a “Participating Blue View Vision Provider” by the Claims Administrator. A Provider who does not participate in the Blue View Vision network is not a Participating Provider.

For this dental coverage, providers in either the Delta Dental PPO or Delta Dental Premier Network are Participating Providers.

Eligibility

Eligibility information listed in the Medicare-Coordinating Plans Member Handbook also applies to the Dental/Vision benefitS described in this insert.

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