Dental/Vision Benefits

This insert will accompany the Member Handbook for The Local Choice Medicare-Coordinating Plans for enrollees who are eligible for and have elected these benefits.

July 1, 2006 or October 1, 2006

The Local Choice
Commonwealth of Virginia
Department of Human Resource Management

T20514 (12/06)

IMPORTANT NOTICE

This insert describes what Dental/Vision services are available for reimbursement under the The Local Choice Retiree 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/Option I.

Throughout this insert there are words which begin with capital letters. In most cases, these are defined terms. See the Definitions sections of Your Member Handbook and/or 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/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. Furthermore, 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 as applicable to Your own coverage), including General Rules Governing Benefits, Exclusions, Basic Plan Provisions, Definitions and Eligibility that are included in Your The Local Choice Retiree 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 Plan Administrator's (see page 4) network will ensure that You are not charged above the Allowable Charge level. If You use a Non-Participating Provider, You will have to pay any charges over the Allowable Charge level, and You may have to file Your own claim.

Since Medicare does not cover routine Dental/Vision services, the Dental/Vision coverage under Your Plan does not coordinate with Medicare. However, You must report any other dental and/or vision 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 Member Handbook.

SUMMARY OF BENEFITS

	Covered Services	You Pay
Dental	Plan pays $1,200 per member per Calendar Year: • Diagnostic and preventive services • Primary services	 $0 of AC* 20% AC*
Vision	Plan pays for the following benefits once every 24 months:	
	Routine eye exam (one)	Remaining cost after Plan pays $40
	Eyeglass frames (one pair)	Remaining cost after Plan pays $75
	Lenses • Single vision eyeglass lenses (one pair), or	Remaining cost after Plan pays $50
	• Bifocal eyeglass lenses (one pair), or	Remaining cost after Plan pays $75
	• Trifocal eyeglass lenses (one pair), or	Remaining cost after Plan pays $100
	• Contact lenses (any type)	Remaining cost after Plan pays $100

* Allowable Charge

WHO TO CONTACT FOR ASSISTANCE

Dental/Vision Plan Administration

Anthem Blue Cross and Blue Shield

Member Services	800-552-2682
Web Address	**www.anthem.com/tlc** Select "Medicare Retirees" under the Plan Information tab.
Mailing/Appeals Address	Anthem Blue Cross and Blue Shield Member Services P. O. Box 27401 Richmond, VA 23279
ID Card Order Line	866-587-6713

Eligibility and Enrollment

Contact your Group Benefits Administrator with questions about eligibility and enrollment.

Program Administration

Department of Human Resource Management

Web Address	**www.thelocalchoice.virginia.gov**
E-Mail	**tlc@dhrm.virginia.gov**

GENERAL RULES GOVERNING BENEFITS

All applicable Rules Governing Benefits listed in the Member Handbook also apply to the Dental/Vision benefits described in this insert. In addition, for dental services covered under these Plans, when classifying a particular service, the Plan Administrator will use the most current edition of a book published by the American Dental Association entitled Current Dental Terminology (CDT). The Allowable Charge for a procedure will be based on the most inclusive code, and the Plan Administrator alone will determine the most inclusive code. No benefits will be provided for lesser included procedures or for procedures which are components of a more inclusive procedure.

DENTAL BENEFITS

Services Which Are Eligible for Reimbursement

1) The following diagnostic and preventive dental services are eligible for reimbursement.

Your Plan provides coverage for You to see Your dentist twice per Calendar Year for a check-up. This allows Your dentist to identify any possible problems and to try to prevent cavities and serious dental problems. Covered services include:

- two routine oral evaluations per Calendar Year;
- two dental prophylaxes (cleanings) per Calendar Year, including scaling and polishing of teeth;
- dental x-rays (except x-rays needed to fit braces) (bitewing x-rays limited to two per Calendar Year);
- one full mouth x-ray or panorex every 36 months;
- direct fluoride application to natural teeth for participants under age 19 (up to two per Calendar Year);
- space maintainers (not made of precious metals);
- pulp vitality tests (up to two tests per Calendar Year);
- palliative emergency treatment;
- biopsies of oral tissue;
- dental pit/fissure sealants on first and second permanent molars for participants under age 19;
- bite planes or splints to increase vertical dimension for temporomandibular joint or associated myofacial pain disorders;
- occlusal adjustments for temporomandibular joint disorders; and
- occlusal nightguards for demonstrated tooth wear due to bruxism.

2) The following primary services are also eligible for reimbursement.

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;
- care for abscesses in the mouth (excision and drainage);
- repair of broken removable dentures;
- surgical preparation of ridges for dentures;
- recementing of existing crowns, inlays and bridges;
- removing infected parts of the gum and replacing them with healthy tissue (gingivectomy and gingivoplasty);
- scaling and root planing of the gum;
- stainless steel crowns for eligible children under age 16;
- sedative fillings;

- therapeutic pulpotomy;
- periodontal evaluations (not in addition to periodic evaluations);
- an operation to remove diseased portions of bone around the teeth (osseous surgery);
- soft tissue grafts;
- bone grafts (only around natural teeth);
- guided tissue regeneration;
- general anesthesia in connection with a covered surgical dental service;
- crown lengthening when bone is removed and at least six weeks are allowed for healing;
- frenectomies;
- hemisection and root amputations;
- apicoectomies;
- periodontal maintenance (limited to two per Calendar Year); and
- trips by the dentist to Your home if You need any of the services You see listed here.

Conditions for Reimbursement

Dental services must be:

- Billed for by a Provider in private practice;
- Services which the Provider is licensed to render; and
- Necessary for the restoration of function or maintenance of dental health.

Special Limits

1) Benefits are limited to $1,200 per Calendar Year for all services. If You transfer to another self-insured plan with the same benefit limit under this health benefits program during the Calendar Year, the combined benefit limit is $1,200.

2) If general anesthesia services are rendered by the same dentist who performs the dental treatment, the Allowable Charge for the services will be 50% of the amount it would have been for them if rendered by someone else.

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

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

Special Exclusions

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

1) services rendered after the date of termination of the covered person's coverage.

2) brush biopsies of the oral cavity;

3) gold foil restorations;

4) athletic mouth guards;

5) dentures;

6) oral, inhalation or intravenous (IV) sedation;

7) bleaching of discolored teeth;

8) dental pit/fissure sealants on other than first and second permanent molars;

9) root canal therapy on other than permanent teeth;

10) pulp capping (direct or indirect);

11) tissue conditioning;

12) separate charges for infection control procedures and procedures to comply with OSHA requirements.

13) separate charges for routine irrigation or re-evaluation following periodontal therapy;

14) analgesics (nitrous oxide);

15) 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;

16) diagnostic photographs;

17) periodontal splinting and occlusal adjustments for periodontal purposes;

18) controlled release of medicine to tooth crevicular tissues for periodontal purposes;

19) tooth desensitizing treatments;

20) care by more than one dentist when You transfer from one dentist to another during the course of treatment;

21) 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;

22) surgical extractions of impacted teeth;

23) preventive control programs, or oral hygiene instructions;

24) complimentary services or dental services for which the participant would not be obligated to pay in the absence of the coverage under this Plan or any similar change;

25) dental services for lost, misplaced or stolen devices that are not covered under this Plan;

26) services that Your Plan determines are for the purpose of cosmetic surgery or dentistry for cosmetic purposes;

27) services that Your Plan determines are for the purpose of correcting congenital malformations or replacing congenitally missing teeth;

28) dental services for increasing vertical dimension, restoring occlusion, correcting developmental malformations, or for esthetic purposes;

29) services billed under multiple dental service procedure codes which Your Plan, in its sole discretion, determines should have been billed under a single, more comprehensive dental service procedure code. Your Plan's payment is based on the allowance for the more comprehensive code, not on the allowances for the underlying component codes; and;

30) any services not listed as covered services, or services determined by Your Plan, in its sole discretion, to be not necessary or customary for the diagnosis or treatment of the condition. Your Plan will take in to 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 Plan pays the remaining Allowable Charge after Your Coinsurance.

Coinsurance (the amount You pay)

Diagnostic and preventive services	0% of Allowable Charge
Primary services	20% 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, every 24 months:

- Single vision lenses, or
- Bifocal lenses, or
- Trifocal lenses, or
- Contact lenses (any kind).

Conditions for Reimbursement

Vision services must be:

- Billed by a Provider in private practice; and
- Services which the Provider is licensed to render.

Special Limits

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

- One routine vision examination, and
- One pair of frames, and
- One pair of non-contact lenses, regardless of the type of lenses, **or** $100 of contact lenses (any kind).

2) Sunglasses, even if by prescription, are excluded.

Reimbursement

The Plan will reimburse up to the amounts stated.

1) For routine vision examination, $40 per exam
2) For frames, $75 per pair
3) For single lenses, up to $50 per pair
4) For bifocal lenses, up to $75 per pair
5) For trifocal lenses, up to $100 per pair
6) For contact lenses, up to $100

Exclusions

In addition to the special exclusions listed in this insert, all applicable exclusions listed in the Member Handbook also apply to the Dental/Vision benefits described in this insert.

Basic Plan Provisions

All applicable Basic Plan Provisions listed in the Member Handbook also apply to the Dental/Vision benefits described in this insert.

Definitions

All applicable Definitions listed in the 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
A Participating Provider is a Provider who is listed as a “Participating Provider” by the Plan Administrator. A Provider who does not participate with the Anthem Blue Cross and Blue Shield of Virginia network is not a Participating Provider under this dental/vision plan.

Eligibility

Eligibility information listed in the Member Handbook also applies to the Dental/Vision benefits described in this insert.