

Dental SelectHMO 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.¹ And there's also research linking poor oral health to diabetes, lung disease and premature births.²

Fortunately, regular dental checkups 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 the Dental SelectHMO plan* from Anthem Blue Cross can help make it easy and affordable.

¹ American Academy of Periodontology: Gum Disease Links to Heart Disease and Stroke, perio.org, 2008.

² National Institute of Dental and Craniofacial Research: Oral Health in America, 2008.

* Available in Alameda, Contra Costa, Fresno, Los Angeles, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara and Ventura. Limited availability in Butte, El Dorado, Imperial, Kern, Madera, Marin, Monterey, San Joaquin, San Luis Obispo, Santa Barbara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare and Yolo. Areas are subject to change.

How the Dental SelectHMO plan works:

Our Dental SelectHMO plan offers comprehensive coverage that is designed to fit your family's budget. Services must be performed by an Anthem Blue Cross Dental SelectHMO participating dentist in order to be covered. Benefits are immediately available for most services and you won't have to meet any deductibles.

Each time you visit a participating dentist, you'll pay a low \$5 office visit fee and a set copayment for some procedures. Once you pay the \$5 office visit fee, most diagnostic and preventive services (such as cleanings, exams and X-rays) are covered in full.

Dental SelectHMO benefits at a glance...

The charts on the next page show copayment amounts for some of the more common services available under the Dental SelectHMO plan.

Take advantage of the plan's many features, including no deductibles and no annual maximums. And people of any age may apply!

Monthly rates (effective 3/1/10) for Dental SelectHMO plan enrollees under age 65*	Monthly rates (effective 3/1/10) for Dental SelectHMO plan enrollees age 65 and over*
Single \$16.50	Single \$13.00
Two Party Member and Spouse or Member and Child \$33.00	Two Party Member and Spouse or Member and Child \$26.00
Family (three or more) (Member, Spouse and Child or Member and Children) \$49.40	Family (three or more) (Member, Spouse and Child or Member and Children) \$39.00

*Subject to change.

Dental HMO plans provided by Anthem Blue Cross. Dental PPO plans provided by Anthem Blue Cross Life and Health Insurance Company. Life plans offered by Anthem Blue Cross Life and Health Insurance Company. Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ©ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

To find a network dentist,
visit anthem.com/ca.

COVERED BENEFITS AND PLAN HIGHLIGHTS

These copayments apply only to services rendered by a participating dentist. Specialty services provided by a participating specialty dentist are a separate schedule in your contract.

Dental Services	Dental SelectHMO Copayments
Office Visit	\$5
Diagnostic Care	
Oral Exams	No Charge
X-rays	No Charge
Preventive Care	
Routine Cleanings (adult and child)	No Charge*
Topical Fluoride (child)	No Charge
Restorative Care	
Filling – Permanent	
1 surface amalgam	No Charge**
Filling – Permanent	
2 surfaces amalgam	No Charge**
Filling – Permanent	
3 surfaces amalgam	No Charge**
Filling – Permanent	
4 or more surfaces amalgam	No Charge**
Filling – Permanent	
1 surface posterior resin composite	\$75

* First two treatments in 12 consecutive months. All additional treatments within a 12-month period require copayments of \$44 for adults and \$35 for children.

** You must meet a six-month waiting period before these benefits are payable.

How to apply for coverage

For Anthem Blue Cross health members who want to add dental, and new members enrolling in dental coverage only:

- Complete and sign the Individual Dental SelectHMO Plan Enrollment Application. Note: The participating dentist that you choose must appear on your application. You and your dependents must select the same participating general dentist.
- Choose your payment plan.*
- Write a check payable to Anthem Blue Cross or use a credit card.
- Send the application and payment** to the appropriate Anthem Blue Cross address below, or to your agent.

For new members enrolling in Anthem Blue Cross health and dental coverage:

- See instructions on the Individual Enrollment Application.

Send your application and payment to one of the following addresses:

Dental SelectHMO Plan enrollees under 65:

Oleg Skurskiy
18375 Ventura Blvd. # 226
Tarzana, CA 91356

by fax 1-818-776-9865

or your Authorized Independent Agent.

* You must select the same payment option for your **dental** plan that you have for your **health** plan.

** Even if you pay your **health** premium by a monthly checking account automatic premium payment, you must send the first month's **dental** premium with the application.

*** Eligibility, rates and billing options for the Dental SelectHMO plan varies for individuals over 65. Please contact your agent or call 800-765-2585 for more information.

MORE BENEFITS AND COPAYMENT HIGHLIGHTS

Dental Services	Dental SelectHMO Copayments
Endodontic Care	
Root Canal	
– Anterior	\$289
– Bicuspid	\$341
– Molar	\$459
Pulpotomy	\$62
Periodontal Care	
Scaling/Root Planing	
– per quadrant	\$101***
Gingivectomy	
– per tooth	\$72
– per quadrant	\$194
Osseous Surgery – per quadrant	\$520
Oral Surgery	
Extraction	
– single tooth	\$60***
Impaction	
– soft tissue	\$136
– partial bony	\$176
– complete bony	\$200
Prosthetic Care	
Crown	
– Porcelain fused high noble metal	\$432
Complete Upper or	\$577
Lower Dentures	
Partial Denture	\$430
Denture (broken tooth repair)	\$57
Orthodontic Care	
Orthodontics (child)	\$2,870
Orthodontics (adult)	\$3,045
Retention	\$210
Cosmetic Care	
Resin Filling (permanent, one surface, posterior)	\$75
Labial Veneer (lamine) – chairside	\$187
Other Services	
Office Visit After Hours	\$56
Local Anesthesia	\$14

*** You must meet a six-month waiting period before these benefits are payable.

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.

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

Enrolling is Simple. Just Follow These 3 Easy Steps...

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: 818-654-4548 fax: 818-776-9865

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction), bi-monthly (every two months) or quarterly (every three months).

Step 3

SEND THE COMPLETED APPLICATION TO:

Oleg Skurskiy
18375 Ventura Blvd. # 226
Tarzana, CA 91356

Please make your check payable to: Anthem Blue Cross

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at: 818-654-4548

Thank you for choosing...





Anthem Blue Cross
Individual Dental SelectHMO Plan Enrollment Application

If you are an Anthem Blue Cross member, please enter your current group number and certificate number.

GROUP NO.	CERTIFICATE NO.
_ _ _ _ _ _ _	_ _ _ _ _ _ _

Enter the number of the Dental Office you have chosen: _____

Application Information: Applicant must complete this section.

PLEASE PRINT

LAST NAME	FIRST NAME	MI	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (Mo/Day/Year)	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M	SOCIAL SECURITY NUMBER
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	
HOME PHONE NO. ()			BUSINESS PHONE NO. ()			

Spouse/Domestic Partner To Be Insured (Sign Below)

NAME OF SPOUSE/DOMESTIC PARTNER	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (Mo/Day/Year)	SOCIAL SECURITY NUMBER
_ _ _ _ _ _ _	_	_ _ _ _ _ _ _	_ _ _ _ _ _ _

Children To Be Insured

NAME (First and Last)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (Mo/Day/Year)	NAME (First and Last)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (Mo/Day/Year)
1. _ _ _ _ _ _ _	_	_ _ _ _ _ _ _	3. _ _ _ _ _ _ _	_	_ _ _ _ _ _ _
NAME (First and Last)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (Mo/Day/Year)	NAME (First and Last)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (Mo/Day/Year)
2. _ _ _ _ _ _ _	_	_ _ _ _ _ _ _	4. _ _ _ _ _ _ _	_	_ _ _ _ _ _ _

Language Preference - When information is sent to you, we may be able to send it in a language other than English. What language would you prefer? (Optional)

Spanish Chinese Korean Japanese Tagalog Vietnamese Khmer Hmong Farsi Arabic Armenian Russian Other _____

Signatures (Required)

Statement of Understanding: I understand that, once enrolled, only the services I receive from my Anthem Blue Cross Dental SelectHMO participating provider will be covered by the plan.

REQUIREMENT FOR BINDING ARBITRATION

The following provision does not apply to class actions:

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS REQUIRES BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration." THIS MEANS THAT YOU AND ANTHEM BLUE CROSS ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN.

SIGNATURE OF APPLICANT/PARENT OR LEGAL GUARDIAN X	TODAY'S DATE	SIGNATURE OF APPLICANT'S SPOUSE/DOMESTIC PARTNER X	TODAY'S DATE
SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER X	TODAY'S DATE	SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER X	TODAY'S DATE

Agent Information and Declaration

To the best of my knowledge, the information on this application is complete and accurate. I have explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understands the explanation. I understand that if I willfully make any false representations I shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to \$10,000.

SIGNATURE OF AGENT X	AGENT NAME (PRINT) OLEG SKURSKIY	AGENT NUMBER BCLNGNPVMZ
_ _ _ _ _ _ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _

FOR ANTHEM BLUE CROSS ONLY

GROUP NO.	CERTIFICATE NUMBER	AGENT NO.	EFFECTIVE DATE	PRE-EXIST	AREA	BY	DATE
_ _ _ _ _ _ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _

