



Anthem Blue Cross Dental SelectHMOSM



This is only an overview of coverage. A comprehensive description of coverage, benefits and limitations is contained in the Evidence of Coverage booklet. Review the Exclusions and Limitations listed in the Evidence of Coverage booklet prior to applying for coverage. For a copy, contact your agent or call Anthem Blue Cross at 800-333-0912.

Anthem Blue Cross
2000 Corporate Center Drive
Newbury Park, CA 91320



Why You Need Dental Coverage

The first-ever Surgeon General's Report on Oral Health confirms that good oral health and your overall wellness are inseparable, calling the mouth "a mirror for general health and well-being."

Why You Need Dental Coverage

Because oral health is so vital to the quality of your life, dental coverage should be an essential part of your health and wellness at any age. It helps you:

- Maintain good oral health throughout your life
- Enjoy the self-esteem that comes from looking your best
- Prevent oral diseases and disorders
- Receive quality care

Remember: Regular dental checkups and cleanings can help detect early signs of oral health problems, reducing the risk of permanent damage to your teeth and gums and preventing costly treatments later on. Also, your dentist may be the first to see signs of a health problem, helping you to keep it from becoming more serious.

Anthem Blue Cross Dental HMO coverage gives you the comprehensive, quality coverage you want from an industry-leading company you can trust. So give yourself the rewards of good dental coverage ... because your smile is a reflection of you.

Anthem Blue Cross Dental plans offer:

- **More choices** – three Dental HMO plans and a large network of dentists to choose from
- **Comprehensive benefits** – a broad range of preventive, basic and major services
- **Specialty services** – orthodontic and cosmetic
- **Affordable monthly rates** – choice of payment options with low \$5 office visit fees for exams, cleanings and X-rays

Access to Savings and Resources

Take advantage of the plans' many features, including no deductibles, no annual maximums and no age limitations. Plus savings of up to 50 percent on health-related products and services through the Anthem Blue Cross SpecialOffersSM Program.

You Have Choices

Choose any Anthem Blue Cross Dental SelectHMO by itself or in combination with your Anthem Blue Cross medical coverage. Our dental coverage is so affordable, you'll want to keep the entire family smiling.



Anthem Blue Cross Dental SelectHMO Plans

Anthem Blue Cross Dental SelectHMO Plans

Anthem Blue Cross invites you to put your best smile forward with one of our three affordable plans: Dental Saver SelectHMO, Dental SelectHMO or Dental Premier SelectHMO.

Covered Benefits and Plan Highlights

These copayments apply only to services rendered by a Participating Dentist.

Finding a plan...

Please use this side-by-side comparison chart to help find the plan that works best for you. Additional plan details are included on the following pages.

Specialty services provided by a Participating Specialty Dentist are a separate schedule in your contract.

Dental Services	Dental Saver SelectHMO copays	Dental SelectHMO copays	Dental Premier SelectHMO copays
Office Visit	\$5	\$5	\$5
Diagnostic Care			
Oral Exams	No Charge	No Charge	No Charge
X-rays	No Charge	No Charge	No Charge
Preventive Care			
Prophylaxis – adult & child	No Charge*	No Charge*	No Charge*
Topical Fluoride – child	No Charge	No Charge	No Charge
Restorative Care			
Filling – Permanent			
1 surface amalgam	\$54	No Charge**	No Charge**
Filling – Permanent			
2 surfaces amalgam	\$64	No Charge**	No Charge**
Filling – Permanent			
3 surfaces amalgam	\$75	No Charge**	No Charge**
Filling – Permanent			
4 or more surfaces amalgam	\$89	No Charge**	No Charge**
Periodontal Care			
Scaling/Root Planing per quadrant	\$101	\$101	No Charge**
Orthodontic Care			
Orthodontics – Child	\$2,870	\$2,870	\$2,870
Adult	\$3,045	\$3,045	\$3,045
Retention	\$210	\$210	\$210
Prosthetic Care			
Denture (broken tooth repair)	\$57	\$57	\$57
Other Services			
Office Visit After Hours	\$56	\$56	\$56
Local Anesthesia	\$14	\$14	\$14

*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 Our Plans Work

Our Dental SelectHMO Plans offer you varying coverage to fit your needs and your 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 possibly a reduced copayment for some procedures. Once you pay the \$5 office visit fee, most preventive and diagnostic services (such as cleanings, exams and X-rays) are covered in full.

These copayments apply only to services rendered by a Participating Dentist. Specialty services provided by a Participating Specialty Dentist are included on a separate schedule in your contract.

More Benefits and Copayment Highlights

Dental Services	Dental Saver SelectHMO copays	Dental SelectHMO copays	Dental Premier SelectHMO copays
Cosmetic Care			
Resin Filling – permanent, one surface, posterior	\$75	\$75	\$75
Labial Veneer (laminare) – chairside	\$187	\$187	\$187
Endodontic Care			
Root Canal – Anterior	\$289	\$289	\$289
– Bicuspid	\$341	\$341	\$341
– Molar	\$459	\$459	\$459
Pulpotomy	\$62	\$62	\$62
Periodontal Care			
Gingivectomy – per tooth	\$72	\$72	\$72
– per quadrant	\$194	\$194	\$194
Osseous Surgery – per quadrant	\$520	\$520	\$520
Oral Surgery			
Extraction – of erupted tooth or exposed root	\$60	\$60	No Charge*
Impaction – soft tissue	\$136	\$136	\$136
– partial bony	\$176	\$176	\$176
– complete bony	\$200	\$200	\$200
Prosthodontic Care			
Crowns	\$432	\$432	\$432
Complete Upper or Lower Dentures	\$577	\$577	\$577
Partial Denture	\$430	\$430	\$430

NOTE: Records, retention and certain corrective interception treatment, all of which are necessary in Orthodontic care, are excluded from coverage in many other plans, but Anthem Blue Cross Dental SelectHMO offers these services at reduced fees.

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

Coverage Information

Eligibility

You and your enrolling dependents must be permanent, legal residents of California and must select the same Dental SelectHMO participating dentist located within 35 miles of your residence.

Eligible dependents include:

- the Policyholder's lawful spouse
- any unmarried child of the Policyholder or the enrolled spouse under age 19
- any unmarried child of the Policyholder or the enrolled spouse ages 19 to 23, who qualifies as a dependent for Federal Income Tax purposes
- any of the Policyholder's, the Policyholder's enrolled spouse's or enrolled Domestic Partner's children who continue to be both incapable of self-sustaining employment due to a continued physically or mentally disabling injury, illness, or condition and who are dependent upon the Policyholder, enrolled spouse or enrolled Domestic Partner for support

Eligibility, rates and billing options for the Dental SelectHMO products vary for Individuals over 65. Please contact your agent or call 800-765-2585 for more information.



Finding Your Participating Dentist

To find a participating dentist near you, visit our website at anthem.com/ca.

Participating dentists are conveniently located in the following California counties:

Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Diego, San Francisco, San Joaquin, San Luis Obispo, Santa Barbara, Santa Clara, Solano and Sonoma. Limited availability in El Dorado, Fresno, Kern, Kings, Monterey, Placer, Riverside, San Bernardino, San Mateo, Santa Cruz, Tulare and Ventura.

Waiting Periods

For Dental SelectHMO and Dental Premier SelectHMO Plans, a six-month waiting period is required for fillings. For Dental Premier SelectHMO Plan, a six-month waiting period is also required for scaling/root planing and oral surgery. More detailed information can be found in your policy.

Date Coverage Begins

The effective date of your plan is assigned by Anthem Blue Cross and will be the first of the month following approval.

Anthem Blue Cross Dental SelectHMO Plan Monthly Rates

	Dental Saver SelectHMO	Dental SelectHMO	Dental Premier SelectHMO
Single	\$11.00	\$15.80	\$19.60
Two Party (Member & Spouse or Member & Child)	\$22.10	\$31.70	\$38.60
Family (three or more) (Member, Spouse & Child or Member & Children)	\$33.10	\$47.50	\$58.20

Exclusions & Limitations

Exclusions and Limitations for Dental SelectHMO Plans

- Experimental or investigative care or therapy.
- Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication, settlement or otherwise, under any workers' compensation or occupational disease law, even if you do not claim these benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, Anthem Blue Cross Life and Health Insurance Company will provide the plan benefits for such conditions subject to its right of recovery and reimbursement under California Labor Code Section 4903.
- Any services for which you are entitled to receive Medicare benefits, whether or not Medicare benefits are actually paid.
- Any services provided by a local, state, county or federal government agency, including any foreign government, except when payment under the plan is expressly required by federal or state law.
- Services or supplies for which no charge is made, or for which no charge would be made if you had no insurance coverage, or services for which you are not legally obligated to pay.
- Services received before your effective date or during an inpatient stay that began before your effective date.
- Services rendered before coverage begins or after coverage ends.
- Prescribed drugs, pre-medication or analgesia (including nitrous oxide).
- No benefits are provided for hospital or associated physician charges for any dental treatment that cannot be performed in the dentist's office because of your general health, mental, emotional, behavioral or physical limitations.
- Unless an exception is specifically authorized by Anthem Blue Cross in writing, dental services must be received from your participating dentist or participating specialty dentist.
- A dental treatment plan, which in the opinion of the participating dentist and/or Anthem Blue Cross is not dentally necessary for dental health or will not produce beneficial results.
- 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.
- Treatment of fractures or dislocations.
- Any treatment to correct a dental condition that resulted from dental services performed by a non-participating dentist while coverage is in effect and any dental services started by a non-participating dentist will not be the responsibility of the participating dentist or Anthem Blue Cross for completion.

- Histopathological exams and/or the removal of tumors, cysts, neoplasms and foreign bodies not covered under the medical plan.
- Teeth with questionable, guarded or poor prognosis are not covered for endodontic treatment, periodontal surgery or crown and bridge. Plan will allow for observation or extraction and prosthetic replacement.
- Services received after the benefit limit under this agreement is reached.
- Orthodontic services must be received from a participating orthodontist. In the event of loss of coverage for any reason, and at the time of loss of coverage you are still receiving orthodontic treatment, you will be responsible for the remainder of the cost for that treatment.
- Replacement of lost or stolen orthodontic appliances or repair of orthodontic appliances that were broken due to negligence.
- Myofunctional therapy and related services.
- Surgical procedures incidental to orthodontic treatment, including but not limited to extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate.
- Changes in treatment necessitated by an accident of any kind.
- Treatment related to the joint of the jaw (temporomandibular joint, TMJ) and/or hormonal imbalance.

These exclusions and limitations are an overview only. The policy contains a comprehensive list of the plan's exclusions and limitations.

You should also know...

Termination of Coverage

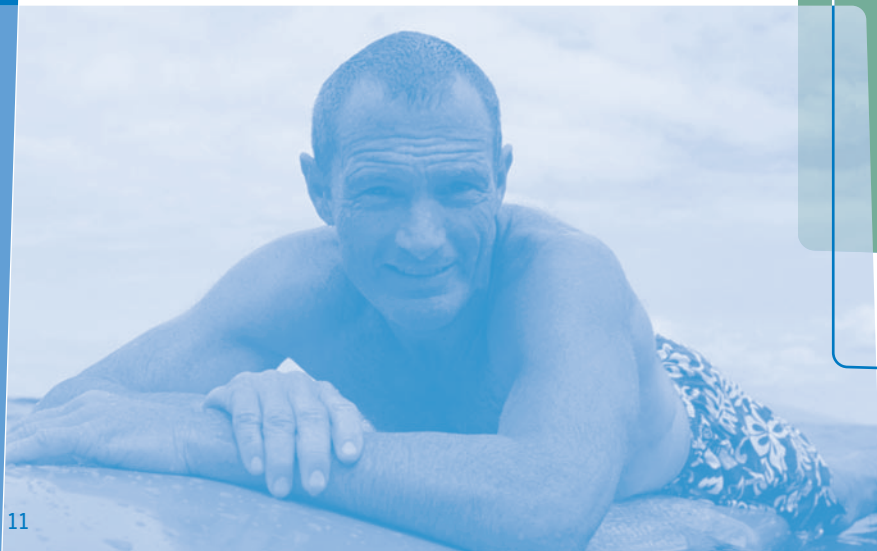
Your dental benefits will end if your premium is not received when it is due (subject to the grace period); you live 35 miles or more from any participating dental group or office; you do not pay copayments; you fail to meet the eligibility requirements listed previously; you become enrolled in any other Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company non-group coverage; you live in a foreign country for more than six consecutive months; or you are absent from California for more than six consecutive months. Anthem Blue Cross must be notified within 30 days of all changes affecting your eligibility.

Non-Duplication of Anthem Blue Cross Benefits

If, while covered under this policy, you are covered by another Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company Individual policy, you are entitled only to the benefits of the policy with greater benefits. The Anthem Blue Cross Companies will refund any premium received under the policy with the lesser benefits, covering the time both policies were in effect. However, any payments made by the Anthem Blue Cross Companies under the policy with the lesser benefits will be deducted from any such refund of premium.

Requirement for Binding Arbitration

If you are applying for coverage, please note that Anthem Blue Cross requires binding arbitration to settle any and all disputes against Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company, including claims of medical malpractice and breach of contract and benefits. This means that you are waiving your right to a jury or court trial for both medical malpractice claims, and any other disputes. 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." Both parties also agree to give up any right to pursue on a class basis any claim or controversy against the other.



How to Enroll

For new members enrolling in dental coverage only:

- Complete and sign the attached application.
Note: The participating dentist that you choose must appear on your application. You and your dependents must select the same participating general dentist.
- Determine your premium.
- 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 medical and dental coverage:

- See instructions on the Individual Enrollment Application.

For Anthem Blue Cross medical members who want to add dental:

- Complete and sign the attached application.
- Determine your premium.
- 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, or to your agent.

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

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

To determine your initial premium:*

- If you want to pay your bill **monthly**, fill out the attached Checking Account Automatic Premium Payment Authorization or credit card authorization along with a check for one month's premium.
- If you want to pay your bill **every other month (bimonthly)**, write a check for two months' premium.
- If you want to pay your bill **every three months**, write a check for three months' premium.

*If you are an Anthem Blue Cross medical plan member, you must select the same payment option for your **dental** plan that you have for your **medical** plan.

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

Dental SelectHMO Plan enrollees under 65:

Anthem Blue Cross
P.O. Box 9051
Oxnard, CA
93031-9051

Dental SelectHMO Plan enrollees over 65:**

Anthem Blue Cross
P.O. Box 9063
Oxnard, CA
93031-9063

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

or your: **Authorized Independent Agent**

Applicant Social Security or ID No. _____

Payment Method (Premium payment required. Please choose from A or B.)

- A. Please choose from the following options for initial payment and future payments. If you choose one of these options, you are not required to send in a paper check for initial payment:**
 Monthly Credit/Debit Card (complete Section C) Monthly Checking Account Automatic Premium Payment (complete Section D)

B. Please choose from the options below for your initial premium payment:

- Paper Check* Electronic Check (complete Section E)
 If you choose one of these two options, you will receive a bill every two or three months thereafter, depending on the billing frequency you select.
 Select Frequency: Bimonthly Quarterly

C. Monthly Credit/Debit Card

As a convenience to me, I request and authorize you to charge my card for monthly recurring premiums on each due date. I understand that the initial payment amount may vary as a result of changes during underwriting and/or subsequent payment amounts may vary as a result of changes I make once enrolled, such as, but not limited to, adding and deleting dependents, or moving my residence. The amount may also change as outlined in my policy. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage.

We accept Visa, MasterCard, Discover and Star*.
 *For Star, we accept 16 digit card numbers only.

Card No.: _____ Exp. : _____ / _____ / _____ Cardholder ZIP Code: _____
 (16 digits only)

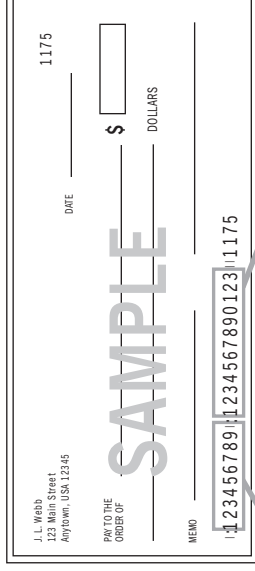
Authorized Signature (As it appears on the credit card) _____ Cardholder Name (As it appears on the credit card) _____ PRINT _____ Date _____
 X

D. Monthly Checking Account Automatic Premium Payment

By providing your check information to the right, you authorize us to electronically debit your bank account. Your bank account will be debited one month's premium the day after approval. 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.



Bank Routing No. _____ Bank Account No. _____

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 Blue Cross provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of changes during underwriting and/or subsequent payment amounts may vary as a result of changes I make once enrolled, such as, but not limited to, adding and deleting dependents, or moving my residence. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem Blue Cross to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross premiums. This authority is to remain in effect until revoked by me by providing you a 30-day written 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 though such dishonor results in forfeiture of insurance. **NOTE:** Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Automatic Premium Payment and be billed bi-monthly. **You will incur a \$25 service charge for any withdrawal not honored.**

Authorized Signature (As it appears in the financial institution's records) _____ Account Holder Name _____ PRINT _____ Date _____
 X

E. Electronic Check

In lieu of sending a Paper Check, we can submit this same information electronically. You will need to complete the information below. We require an exact amount and check number of the check you are using. Please void this check to prevent future use.

Account Holder Name _____ PRINT _____ Bank Routing No. _____ Account No. _____ Amount _____ Check No. _____
 \$ _____

* Enclose check for first month's payment. By sending your paper check, you authorize us to convert your check to an electronic fund transfer. If you are approved for coverage, your bank account will be debited for the amount indicated on the check. If you do not qualify for coverage, your check will not be submitted for a funds transfer. Please be aware that your check will not be returned to you.