Dental Blue® Plans for Individuals and Families

For dental benefits you can smile about!

Anthem Blue Cross
Health. Join In.
HEALTH | DENTAL | LIFE

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 check-ups 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 Blue plans from Anthem Blue Cross Life and Health Insurance Company 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.

How the Dental Blue plans work:

We offer two great Dental Blue plans to choose from: Dental Blue Basic and Dental Blue Enhanced. The Dental Blue Basic plan provides coverage for many diagnostic services and preventive care such as cleanings, exams and X-rays, as well as fillings, with an annual maximum of $500. The Dental Blue Enhanced plan includes cleanings, exams, X-rays and fillings — plus certain major services like root canals, periodontal procedures and crowns, with an annual maximum of $1,250. It also includes orthodontic coverage for children after a 12-month waiting period.

A unique feature of Dental Blue is that members have access to the rates Anthem has negotiated with providers during any applicable waiting periods, after the annual maximum has been met, and for certain non-covered services like veneers, dental implants and TMJ treatment. These discounts are available only at in-network providers.

Lastly, as a Dental Blue plan member, **you can see any dentist you want**; however, you do have the potential for lower costs when you choose a dentist in the Dental Blue 100 network. This is because in-network dentists have agreed to accept our fee schedule for services rendered.

If you choose to go to a provider outside of the Dental Blue 100 network, you can be billed the difference between what we pay our in-network dentists and what your chosen dentist wishes to charge. But, with more than 18,000 California dentists in our Dental Blue 100 network, it's likely your dentist is part of our network!

Dental Blue benefits-at-a-glance...

The chart below shows the covered benefits and amounts we pay for both of our Dental Blue plans.

	Dental Blue Basic		Dental Blue Enhanced	
	In-network	Out -of-network	In-network	Out -of-network
Annual Deductible	$25 per member		$50 per member/$150 maximum per family	
Waive d for Diagnostic and Preventive	Yes	No	Yes	No
Annual Maximum	$500		$1,250	
Diagnostic and Preventive Services Cleanings, exams and X-rays	100%	80%	100%	80%
Basic Services				
Fillings	80%	60%	80%	60%
Other Minor Restorative	Not covered			
Major Services				
Oral Surgery	Not covered		50%	
Endodontics	50% — coverage for pulpotomies on primary teeth only		50%	
Periodontics	Not covered		50%	
Prosthodontics	50% - coverage for stainless steel crowns on primary teeth only		50%	
Orthodontics	Not covered		Children only 50%, $100 deductible, $500 annual/$1,000 lifetime maximum	
Waiting Periods	No waiting period for cleanings, exams and X-rays; six-month waiting period for all other covered services		No waiting period for cleanings, exams and X-rays; six-month waiting period for basic services; 12 months for major services/orthodontics	

The amounts shown above reflect what we will pay after any deductibles have been met.

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Rating areas

Dental Blue plans are available in the areas listed below. To determine your monthly plan premium, locate your rating area based on the ZIP code of your primary residence, and then refer to the rate charts on Page 3.

Availability

Availability may be limited in some counties. If you live in any of these areas, please review the Statement of Understanding on the application before choosing this plan.

Counties with limited availability*

Area 3: Alpine, Amador, Inyo, Mono
Area 4: Calaveras
Area 5: Del Norte, Humboldt, Lake, Lassen, Modoc, Plumas, Sierra, Siskiyou, Tehama, Trinity
Area 6: Inyo

*As of 11/30/09.

Rating areas

Alameda	ZIP codes starting with 945, 946 and 953, except 94505, 94514	Area 4
	All other Alameda ZIPs	Area 3
Alpine		Area 3
Amador		Area 3
Butte		Area 5
Calaveras		Area 4
Colusa	95957	Area 3
	Except 95957	Area 5
Contra Costa	All except 94551	Area 3
	94551	Area 4
Del Norte		Area 5
El Dorado		Area 3
Fresno	93313	Area 5
	All except 93313	Area 6
Glenn		Area 5
Humboldt		Area 5
Imperial	92225 and 92274	Area 4
	92004	Area 5
	All except 92225, 92274, 92004	Area 6
Inyo	All except 93527	Area 3
	93527	Area 6
Kern	ZIP codes starting with 933	Area 5
	All other Kern ZIPs	Area 6
Kings		Area 6
Lake		Area 5
Lassen		Area 5
Los Angeles	ZIP codes starting with 901-904 and 913	Area 4
	ZIP codes starting with 905-908, 935, 91709 and 93243	Area 6
	ZIP codes starting with 900, 914 or 916	Area 2
	ZIP codes starting with 910-912, 915, 917 or 918, except 91709	Area 7
Madera		Area 6
Marin		Area 1
Mariposa	95329	Area 4
	All except 95329	Area 6
Mendocino		Area 5
Merced	95380	Area 4
	All except 95380	Area 6
Modoc		Area 5
Mono		Area 3
Monterey	All except 95076 and 93451	Area 1
	95076	Area 4
	93451	Area 6
Napa	94589, 94590	Area 3
	All except 94589, 94590	Area 5
Nevada	95602	Area 3
	All except 95602	Area 5
Orange	ZIP codes starting with 926	Area 5
	all Orange ZIPs	Area 6
Placer	All except 95692, 96161	Area 3
	95692, 96161	Area 5
Plumas		Area 5
Riverside	ZIP codes starting with 922 except 92248	Area 4
	92028	Area 5
	All other Riverside ZIPs	Area 6
Sacramento	ZIP codes starting with 958	Area 5
	All other Sacramento ZIPs	Area 3
San Benito	93930, 95004	Area 1
	All except 93210, 93930, 95004	Area 4
	93210	Area 6
San Bernardino	Except 91766, 91792	Area 6
	91766 and 91792	Area 7
San Diego		Area 5
San Francisco		Area 3
San Joaquin	94505, 94514, 95632, 95690	Area 3
	All except 94505, 94514, 95632, 95690	Area 4
San Luis Obispo	93426	Area 1
	All except 93426	Area 6
San Mateo	Except 94303	Area 1
	94303	Area 3
Santa Barbara		Area 6
Santa Clara	ZIP codes starting with 940, 943	Area 3
	94550, 95023, 95076	Area 4
	All other Santa Clara ZIPs	Area 5
Santa Cruz	All except 95033	Area 4
	95033	Area 5
Shasta		Area 5
Sierra		Area 5
Siskiyou		Area 5
Solano	All except 94503, 95616, 95618, 95694	Area 3
	94503, 95616, 95618, 95694	Area 5
Sonoma		Area 5
Stanislaus	All except 95322	Area 4
	95322	Area 6
Sutter	All except 95645, 95692, 95836, 95948, 95837	Area 3
	95645, 95692, 95836, 95837, 95948	Area 5
Tehama		Area 5
Trinity		Area 5
Tulare		Area 6
Tuolumne	95230, 95329	Area 4
	All except 95230, 95329	Area 6
Ventura	ZIP codes starting with 930 or 932	Area 6
	All other Ventura ZIPs	Area 4
Yolo		Area 5
Yuba		Area 5

Monthly rates*

Dental Blue Basic							
Area	1	2	3	4	5	6	7
Member	$22	$23	$20	$21	$20	$19	$21
Member and Spouse	$42	$45	$39	$40	$39	$37	$41
Member and Child	$45	$49	$43	$44	$43	$40	$44
Member and Children	$77	$83	$72	$73	$72	$67	$74
Member and Family	$93	$101	$87	$89	$87	$82	$90
One Child	$24	$26	$22	$23	$22	$21	$23
Two Children	$48	$52	$45	$46	$45	$42	$46
Three+ Children	$78	$84	$73	$74	$73	$68	$75

Dental Blue Enhanced							
Area	1	2	3	4	5	6	7
Member	$44	$54	$45	$50	$49	$46	$62
Member and Spouse	$84	$102	$84	$93	$92	$86	$116
Member and Child	$77	$94	$78	$86	$85	$79	$107
Member and Children	$125	$152	$125	$139	$137	$128	$173
Member and Family	$157	$192	$158	$176	$174	$162	$218
One Child	$33	$40	$33	$37	$36	$34	$46
Two Children	$66	$80	$66	$73	$72	$67	$91
Three+ Children	$107	$131	$108	$119	$118	$110	$149

*Subject to change.

How to apply for coverage

If you are enrolling in dental coverage only, or if you are a new or existing Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company health member who wants to add dental coverage:

- Complete and sign the Individual Enrollment Application.
- Determine your premium.
- Choose your method of payment.
- Send the application and payment to the address below or to your agent.

Please note that when you enroll in both a health and dental plan, the same method of payment must be selected for both. For members with a health plan who are adding dental coverage, you will need to send the first month's dental premium with the application even if you currently pay your health premium by credit card or via automatic monthly checking account deduction.

Send your application and payment to:

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

or by fax : 1-818-776-9865

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 Life and Health Insurance Company 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

SEND COMPLETED APPLICATION BY FAX 818-776-9865

Anthem Blue Cross

Anthem Blue Cross Life and Health Insurance Company
Individual Dental Plan Enrollment Application

If you are an Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company member, please enter your current group number and certificate number.

GROUP NO.	CERTIFICATE NO.

Plan choice - *select one*

☐ Dental Blue Basic
☐ Dental Blue Enhanced

Application Information: Applicant must complete this section. **PLEASE PRINT**

LAST NAME	FIRST NAME	MI	SEX	BIRTHDATE (Mo/Day/Year)	MARITAL STATUS	SOCIAL SECURITY NUMBER
			☐ M ☐ F		☐ S ☐ M	

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/Qualified Domestic Partner To Be Insured (Sign Below)

NAME OF SPOUSE/DOMESTIC PARTNER	SEX	BIRTHDATE (Mo/Day/Year)	SOCIAL SECURITY NUMBER
	☐ M ☐ F		

Children To Be Insured

NAME (First and Last)	SEX	BIRTHDATE (Mo/Day/Year)	NAME (First and Last)	SEX	BIRTHDATE (Mo/Day/Year)
1.	☐ M ☐ F		3.	☐ M ☐ F	
2.	☐ M ☐ F		4.	☐ M ☐ F	

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 for Dental Blue plan applicants in areas with limited availability: I understand the difference between a Participating Dentist and a Non-Participating Dentist, and would like to apply. I know that I probably will not be able to use a Participating Dentist and that I will probably pay more for dental care. When I use Non-Participating Dentists, I will pay the difference between the limited benefit that the plan pays and the actual charge by the Non-Participating Dentist. This means that I may be responsible for a larger portion of my dental bills.

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 AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. ***It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including 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 AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY 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/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.**

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

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	AGENT NAME (PRINT)	AGENT NUMBER
X	OLEG SKURSKIY	BCLNGNPVMZ

FOR ANTHEM BLUE CROSS ONLY

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

BCLNGNPVMZ

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:** ☐ Credit/Debit Card *(complete Section C)* ☐ Monthly Checking Account Automatic Premium Payment *(complete Section D)*

If you choose Credit/Debit Card, please select the frequency you would like your premiums deducted: ☐ Monthly ☐ Bi-Monthly ☐ Quarterly

NOTE: If no selection is made, this option will default to monthly.

☐ **B. If you did not select an option in Section A, please choose from the options below for your initial premium payment:**

☐ Paper Check* ☐ Electronic Check *(complete Section E)* ☐ Credit/Debit Card *(complete Section C)*

If you choose Credit/Debit Card, please select the number of months for your initial premium payment debit: ☐ One Month ☐ Two Months ☐ Three Months

NOTE: If no selection is made, the default debit will be one month's premium for initial payment. If you choose one of these three options, you will receive a bill every two months thereafter.

C. 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 change(s) during underwriting and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, or moving my residence. If I provided my credit/debit card for the initial payment only in Section B, recurring payments will not be charged from my card. 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. _____ *(16 digits only)* Exp. ___/___ Cardholder ZIP code. _____–_____

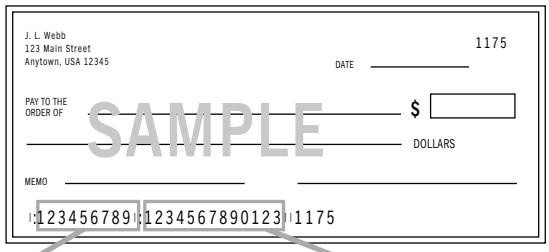
Authorized Signature *(As it appears on the credit card)*	Cardholder Name *(As it appears on the credit card)* PRINT	Date
X		

D. Monthly Checking Account Automatic Premium Payment

By providing your check information to the right, you authorize us to electronically debit your bank account. If you have not selected an initial premium payment option from Section B, 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 6th 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 charge my account for monthly recurring premiums on each due date. I understand that the initial payment amount may vary as a result of change(s) during underwriting and/or subsequent payment amounts may vary as a result of change(s) 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 and/or Anthem Blue Cross Life and Health Insurance Company to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company 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 every two months. **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

Instead 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.
			$	

** When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day we receive your payment, and you will not receive your check back from your financial institution.*

Dental Blue PPO plans provided by Anthem Blue Cross Life and Health Insurance Company.